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OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY INCOME AND QUALIFIED MEDICARE BENEFICIARY PROGRAMS

HEARING BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY THE SUBCOMMITTEE ON HEALTH AND THE SUBCOMMITTEE ON HUMAN RESOURCES OF THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES ONE HUNDRED SECOND CONGRESS SECOND SESSION

MARCH 26, 1992

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OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY INCOME AND QUALIFIED MEDI- CARE BENEFICIARY PROGRAMS

THURSDAY, MARCH 26, 1992

**HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND
MEANS, SUBCOMMITTEES ON SOCIAL SECURITY, HEALTH,
AND HUMAN RESOURCES,**

Washington, DC.

The subcommittees met, jointly, pursuant to notice, at 10:02 a.m., in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the Subcommittee on Social Security) presiding.
[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 17, 1992

PRESS RELEASE #11
SUBCOMMITTEE ON SOCIAL SECURITY
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-9263

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN,
SUBCOMMITTEE ON SOCIAL SECURITY,
THE HONORABLE PETE STARK (D., CA.), CHAIRMAN, SUBCOMMITTEE ON HEALTH,
AND THE HONORABLE THOMAS J. DOWNEY (D., N.Y.), ACTING CHAIRMAN,
SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCE A JOINT HEARING ON
OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY INCOME (SSI)
AND QUALIFIED MEDICARE BENEFICIARY PROGRAMS

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Social Security, the Honorable Pete Stark (D., Ca.), Chairman, Subcommittee on Health, and the Honorable Thomas J. Downey (D., N.Y.), Acting Chairman, Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittees will hold a joint hearing on outreach efforts in the Social Security, Medicare, and Supplemental Security Income (SSI) programs. The hearing will be held on Thursday, March 26, 1992, in room 1100 Longworth House Office Building, beginning at 10:00 a.m. Testimony will be received from invited witnesses only.

BACKGROUND:

The Department of Health and Human Services (HHS) operates a number of programs aimed at assisting low-income disabled or elderly individuals. These programs include SSI, Medicare and Medicaid. The Social Security Administration (SSA) administers SSI, and the Health Care Financing Administration (HCFA) administers Medicare. Medicaid is administered jointly by HCFA and the States.

However, it has been apparent that some of these programs do not reach all of their target populations. For a variety of reasons, otherwise eligible individuals do not enroll in these programs and thus do not receive the benefits Congress has intended. Advocates have criticized SSA and HCFA for a lack of effective outreach -- particularly to disabled homeless persons and children eligible for SSI benefits, and to low-income "Qualified Medicare Beneficiaries," who are eligible for assistance with their Medicare premiums, deductibles and co-insurance.

With respect to SSI, Commissioner of Social Security Gwendolyn King has directed field offices to establish working partnerships with community organizations. Some offices report operating outreach activities with local social service agencies, soup kitchens, homeless shelters and churches to screen individuals for possible SSI eligibility, refer them to local SSA offices, and help them navigate the system. However, it is not known how widespread these activities are. SSA has also established a number of demonstration projects on outreach activities aimed at target groups, such as the aged, children, the mentally ill, homeless persons, and individuals infected with the human immunodeficiency virus (HIV).

Despite these efforts, advocates for disabled children, the elderly and the homeless claim that many individuals fail to enroll due to lack of knowledge about the SSI program and other barriers to participation. For example, it has been estimated that one-third to one-half of aged individuals eligible for SSI do not participate in the program.

The Qualified Medicare Beneficiary (QMB) program has also failed to enroll large numbers of potentially eligible individuals. Enacted in 1988, this Medicaid buy-in program is intended to protect low-income Medicare beneficiaries from out-of-pocket costs under the Medicare program. It requires Medicaid to pay Medicare premiums,

deductibles and coinsurance for elderly and disabled Medicare beneficiaries whose incomes are at or below 100 percent of the Federal poverty level, and whose resources are at or below twice the resource standard used under the SSI program. Beginning in 1993, coverage of Medicare premiums will be phased-in for individuals with incomes up to 120 percent of the Federal poverty level.

The QMB program is administered through State Medicaid agencies; however, all potentially eligible beneficiaries are enrolled in Medicare, which is administered by HCFA. While HHS sent a mailing to 14 million likely beneficiaries and has revised the Medicare handbook, there is evidence that large numbers of Medicare beneficiaries remain unaware of the benefits to which they may be entitled. According to a recent study, more than 2 million seniors nationwide are eligible for the Medicaid buy-in, but are not enrolled in the new program.

SCOPE OF HEARING:

The hearing will examine the outreach efforts of SSA and HCFA in disseminating information about potential eligibility for SSI and QMB benefits, and their success (or lack thereof) in enrolling eligible individuals. Representatives from SSA and HCFA will be questioned about each agency's current and planned efforts in these areas. The Subcommittees will also receive testimony from advocates about the need for additional outreach efforts and about new methods of reaching eligible individuals.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any persons or organizations wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Thursday, April 9, 1992, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing a written statement wish to have their statements distributed to the press and interested public at the hearing, they may deliver 100 additional copies for this purpose to the Subcommittee, room B-316 Rayburn House Office Building, on the day of the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Chairman JACOBS. It is 10 o'clock, and we will determine whether all is well.

This hearing today of the Ways and Means Subcommittees on Social Security, Health, and Human Resources is on the question of whether the Medicaid payment of premiums under Medicare part A and B and deductibles could be better administered by the local Social Security offices, a sort of one-stop lot, I suppose you would say, rather than in diverse places, so that the left hand would know what the right hand was doing.

And I yield to my cochairman, Mr. Bunning, to make his pitch—I mean, make his statement. [Laughter.]

Mr. BUNNING. Thank you, Mr. Chairman, and I have just a very short statement I would like to put into the record.

I would like to start off the hearing by complimenting Commissioner King and the many field office employees, State employees, and volunteers who have worked so diligently to find the so-called missing SSI applicants.

Twenty years ago when this search first started to take place, it was assumed that the SSI rolls would more than double. After numerous mailings which numbered into the millions, along with press releases, national TV and radio spots, and door-to-door canvassing, what actually happened was that of the many leads SSA received, most people ended up being ineligible for benefits.

I also think it should be noted that despite these low outreach results, SSA was applauded by the Democratic Senate Finance Committee in 1987 for its "efforts to reach the potential eligible population" and that SSA "* * * exceeded the implied mandate of an agency to publicize its program."

The limited success of outreach is not confined to SSA either. From what I understand, the Medicare Program has had an even harder time in trying to contact those who are eligible for the qualified Medicare beneficiary program.

After hearing all that SSA has tried to do in order to locate potential SSI recipients, I think it is reasonable to question how much outreach efforts we expect from our agencies, States, and volunteers.

I look forward to hearing from today's witnesses and appreciate their interest in the outreach challenge.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Bunning.

I echo Mr. Bunning's compliments to the Social Security Administration under Gwen King and Lou Enoff and others. It has been quite exemplary, I think.

Mr. Downey, the acting chairman of the Human Resources Subcommittee of Ways and Means, has a statement which he has requested that we put in the record, and without objection, that statement will be included.

Mr. Stark, the chairman of the Health Subcommittee of Ways and Means, has a statement which he has requested that we put in the record, and without objection, that statement will be included.

[The prepared opening statements of the Messrs. Downey and Stark follow:]

OPENING STATEMENT OF
THE HONORABLE THOMAS J. DOWNEY,
ACTING CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON WAYS AND MEANS
HEARING ON OUTREACH IN THE
SUPPLEMENTAL SECURITY INCOME (SSI) AND
QUALIFIED MEDICARE BENEFICIARY PROGRAMS
MARCH 26, 1992

Nearly a decade has passed since Congress first attempted to expand outreach efforts in the Supplemental Security Income Program. Despite this effort, additional legislation, and commendable efforts by Social Security Commissioner Gwendolyn King, there is a lingering suspicion that we are not doing enough. Today, we hope to find out if this is true, and if so, what Congress and the Administration could do to improve this situation.

The Social Security Amendments of 1983 mandated two separate outreach activities aimed at the aged population. The first effort was a one-time mailing of SSI alerts to aged persons whose income was below SSI benefits and the second was an ongoing activity aimed at those about to reach 65 years old, and disabled individuals who had been receiving Social Security benefits for some time and would soon be eligible for Medicare. The one-time mailing of 7.6 million notices yielded about 58,000 new SSI awards to the elderly and the ongoing program brings in an estimated 2,000 additional awards each month.

The Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children. Shortly after its enactment, the United States Supreme Court in *Zebley v. Sullivan* held that the Social Security Administration had been illegally denying disabled children benefits since the beginning of the program in 1974. In implementing the *Zebley* decision, SSA has attempted to contact the families who had been illegally denied benefits, but it is not clear that it has implemented fully the ongoing outreach program required by the 1989 Act.

In addition, Congress has appropriated \$15 million in the last three years for SSI outreach activities. To SSA's credit, it has funded various SSI outreach demonstration projects, but most of these projects seem to focus mainly on the elderly and largely ignore disabled children and homeless adults.

Outreach to the homeless is of particular concern, because many are mentally handicapped. Not only do many of these individuals not know about the SSI program, but they are incapable of sustaining the effort necessary to document eligibility for SSI. They need assistance, but when Congress tries to provide the extra assistance, we are told by the Congressional Budget Office that it would cost more than one billion dollars over a five-year period.

It is a cruel irony that many who are eligible for SSI cannot receive benefits because the very impairments which qualify them for benefits impede them from applying for these benefits. I can only wonder whether the Administration is using stealth technology to keep SSI a secret from disabled children, the elderly, and homeless adults in a callous attempt to control entitlement costs. I do not want to believe this is true, and I look forward to today's testimony with the hope that SSA is doing more than has been apparent to date.

**OPENING STATEMENT
THE HONORABLE PETE STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS**

**HEARING ON OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY
INCOME AND QUALIFIED MEDICARE BENEFICIARY PROGRAMS**

MARCH 26, 1992

Good Morning. I am pleased to be here with my colleagues from the Subcommittees on Social Security and Human Resources for this joint hearing on outreach efforts for the SSI and the Medicaid buy-in programs.

Participation rates in both programs are lamentably low. Over 2 million poor seniors are paying more than they should for Medicare, and more than half of all individuals eligible for SSI are not receiving their monthly benefits.

The buy-in program requires Medicaid to pay premiums, deductibles and copayments for Medicare beneficiaries with incomes below 100% poverty.

The program was enacted in 1988, and strengthened in 1990, for the specific purpose of protecting the poorest seniors from Medicare's substantial cost-sharing requirements.

Over the past decade, Medicare premiums, deductibles and coinsurance have increased dramatically.

- * The Part B premium has increased from \$8.70 per month in 1980 to \$31.80 per month in 1992;
- * The Part A deductible has increased from \$78.00 in 1980 to \$652.00 in 1992; and

The Part A premium, paid by retired school teachers and other state and local employees, has increased from \$22.50 per month in 1980 to an astounding \$192.00 per month in 1992.

I regret to say that this Administration and too many States have done an abysmal job implementing the 1988 law. In California, for example, less than 15% of eligible low-income seniors are enrolled for Medicaid buy-in benefits.

These disappointing findings are neither inevitable nor defensible. If States were to implement the law as it was intended, with a reasonable amount of support from the Administration, then those who are eligible for benefits would receive them. It is very straight forward.

For example, Washington State appears to have a highly successful Medicaid buy-in program -- principally because the State has worked aggressively to develop a program and train state personnel to identify and enroll eligible beneficiaries.

Unfortunately, the Reagan/Bush Administrations have shown little interest in helping Americans who are entitled to SSI or Medicaid buy-in coverage. With minimal effort, the Administration could work with States to reach out to those who are eligible for benefits.

Their lackluster performance means that millions of low income seniors must struggle needlessly to pay Medicare premiums, deductibles and coinsurance.

There is no justification for such low participation rates. We must do a better job to help millions of low income Americans entitled to benefits under the SSI and Medicaid buy-in programs.

Chairman JACOBS. Our first witness today, from Wisconsin, is the Honorable Jim Moody, member of this committee.

[Pause.]

Chairman JACOBS. The elevator may be weighted down, so we will go on to the next witness, Mr. Peter Kostmayer, from the great Keystone State of Pennsylvania, who is our first audible witness.

STATEMENT OF HON. PETER H. KOSTMAYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. KOSTMAYER. Well, thank you very much, Mr. Chairman.

I appreciate the opportunity to testify before you and my friend from Kentucky, and I will be very brief and ask unanimous consent that my statement be included in the record.

Chairman JACOBS. Without objection.

Mr. KOSTMAYER. Mr. Chairman, as you know, in 1988, we passed the catastrophic health bill. There was a good deal of criticism from across the country, and we repealed it in 1989, although I was one of, I think, about 49 or 50 Members who voted against the repeal. But it was repealed.

But there was, as you know, an important provision which was not repealed in 1989, which is still in the law. It is called the Qualified Medicare Beneficiary Program, QMB, sometimes known as Quimby.

This is a very simple law. What it says is that people on Medicare who are poor will have the Federal Government pick up the cost of their monthly premium and deductible. That means that people who live alone, who earn under \$6,800 a year, will have that cost paid by the Federal Government, and couples who earn under \$9,100 a year will have that cost paid every month by the Federal Government.

There are 4.2 million people in the country who qualify for that benefit. There are 2.1 million who are taking advantage of it. There are 2.1 million who are not taking advantage of it. And the reason that those 2.1 million elderly poor Americans are not taking advantage of it is because they do not know about it. In fact, 52 percent of the people in the country who qualify to have the Federal Government pick up their monthly premium are not having it done.

In the State of Indiana, Mr. Chairman, 65 percent of your citizens who are poor and elderly are not having this monthly cost paid. In the State of Kentucky, it is 33 percent. Different States have different kinds of outreach programs; that is why the figures are different.

My bill would do, very simply, two things—really one thing. It would simply have the Government notify these people by putting a simple notice and a simple, short, easy to fill out application in what is called the annual Medicare notice, which every Medicare recipient gets every year.

We tried to figure out a way to target these 2.1 million people, so only they would get the notice and not the 30-plus million people on Medicare. They tell us over there they cannot do that; it is too difficult. So we have got to send it to everybody. It costs a couple of million dollars.

The big cost, of course, Mr. Chairman, is paying for these people. That would cost something over \$2 billion. But I think it is a worthwhile expenditure.

It is the law. We are not talking about whether this is a good policy or a bad policy. The Congress and the President have decided it is a good policy. These are among the poorest people in our country. A disproportionate share of them are women, elderly women who live in big cities, who are paying this because they do not know the Government will help them with it.

I think we ought to let them know about it, ought to pay for it, and that is what my legislation would do. And I appreciate the opportunity to testify and apologize for consuming as much of your time as I have.

[The prepared statement follows:]

PETER H. KOSTMAYER
8TH DISTRICT, PENNSYLVANIA

Congress of the United States
House of Representatives
Washington, DC 20515-3808

March 26, 1992
Hearing before the Committee on Ways and Means
Peter H. Kostmayer
Member of Congress

I want to thank the chairman for holding this joint hearing and bringing additional attention to the Qualified Medicare Beneficiary (QMB) program.

In 1988, Congress passed the Catastrophic Coverage Act. While a year later many in Congress, responding to the overwhelming outcry of senior citizens, voted to repeal the Act, there was one provision of the catastrophic bill which Congress choose to keep: that was the expansion of the QMB program.

The QMB program assists Medicare beneficiaries by allowing Medicaid to pay their Medicare premiums, co-payments and deductibles. This program is essential for Medicare recipients who earn too much to qualify for Medicaid, yet are unable to pay their Medicare out-of-pocket-expenses. In the last decade, Medicare out-of-pocket-costs have risen 216%. An individual who is hospitalized once may be liable for thousands of dollars.

Unfortunately, the Administration apparently does not recognize this same importance. Congress mandated the expansion of this program, but the Administration refuses to inform anyone about it.

More than half of the estimated 4.2 million individuals eligible for the QMB program have not applied for benefits. Most of these individuals have never heard of the QMB program. They are senior Americans who earn less than \$7000 a year as individuals or \$9000 as a couple. Many are spending up to 1/16th of their income on Medicare; others are forgoing health insurance altogether.

Currently, the only way to find out about the QMB program and apply for benefits is through the Public Assistance Office. Most of those eligible for this program have never received any form of assistance and have no other way of hearing about or applying for this program.

I first realized there was a problem with this program last year while visiting a senior center in my district. While discussing a number of issues of concern to seniors, I mentioned the QMB program. I was not only faced with blank stares but with one particularly feisty senior, who adamantly argued that I was wrong, that if there was such a program she certainly would be receiving it. She earned less than \$6,000 a year and was facing out of pocket medical costs of over \$1000. My staff was able to enroll her in the program but I was left wondering how many seniors were in a similar situation.

My immediate reaction was to put together a simple piece of legislation, HR 3251. This legislation mandates that Medicare inform people about this program and provide them with a simple application in their annual notice. I then worked with my good friend from Wisconsin putting together the more comprehensive legislation, HR 3473, which he has already described.

Since the reports on the lack of participation in this program, I assumed that the Administration and the states would do all that they could to enroll qualified beneficiaries. Many in Congress certainly went to great lengths to inform seniors about QMB benefits. I personally mailed a notice to all seniors in my district informing them of this program and had my staff assist seniors in filling out the applications and following through with the assistance office.

But neither the Administration nor the states are making similar efforts. Last week a woman from AARP in Pennsylvania called to tell me that it took her seven phone calls to find out any information about the QMB Program, and when she finally did get information from the Medicare office, she was given the wrong income criteria.

Clearly, something needs to be done. Neither well-publicized reports by consumer groups nor piecemeal efforts by members of Congress are working. In the last nine months, despite considerable efforts, QMB enrollment has only increased .4%. There needs to be a nationwide comprehensive approach which will inform all seniors about these benefits and make it easy to apply. The legislation I have proposed will allow seniors to receive a promised benefit which they desperately need.

Quimby is a good benefit. It is a needed benefit. It should not be a secret benefit.

Chairman JACOBS. Thank you, Mr. Kostmayer.

Mr. Bunning.

Mr. BUNNING. I have no questions.

Chairman JACOBS. I know I have a question. If you send it to the Medicare recipients, what about the people who, for one reason or another, are eligible but are not on the rolls for Medicare at present?

Mr. KOSTMAYER. The only eligible people are current Medicare beneficiaries. To qualify, you have to be a Medicare beneficiary.

Chairman JACOBS. My understanding was that you could buy into the system; is that not true, even if you are not a Medicare beneficiary?

Mr. KOSTMAYER. Well, we think probably this is the best way to get to most of the people. We are looking and exploring, but we think we would get to most of the people, and the people over at Medicare tell us this would be the best way to reach most of the people.

Chairman JACOBS. Well, thank you very much.

Mr. KOSTMAYER. Thank you.

Chairman JACOBS. It is a pleasure to have a man who takes care never to split his infinitives.

And our next witness is the Honorable Frank McCloskey, who is also erudite and Hoosieristic and so on.

Mr. McCloskey.

STATEMENT OF HON. FRANK McCLOSKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. McCLOSKEY. I get a little claustrophobic in a small chamber, Mr. Chairman.

Chairman JACOBS. Yes, I understand. We call it—at McDonald's, we call it McCloskey-phobic, but go ahead.

Mr. McCLOSKEY. Thank you very much for your courtesy and graciousness, Mr. Chairman, Mr. Bunning, and for your interest in this issue.

I will be very brief and ask permission to have my formal statement entered into the record.

Chairman JACOBS. Without objection.

Mr. McCLOSKEY. I would say also that my distinguished colleague, Mr. Kostmayer, stated the problem and the background very well.

I have submitted two bills, a second one with the sponsorship also of Congressman Nick Rahall of West Virginia, Mr. Chairman, and we basically say that the most simple, administratively efficient, direct, and correct way to solve the QMB enrollment problem would be to have the QMB determination made at the local Social Security office when people initially fill out their applications for Medicare. This could be one-stop shopping, in effect.

I think also that the Social Security offices, with the work that they do with disability claims are well equipped to do this.

The administration has not exactly, as we all know, jumped on this idea, complaining of cost and administrative burden, but I believe their figures show that the cost would be \$18 million a year. Obviously, I think their true concerns may go beyond that, I think,

to arbitrarily and, quite frankly and very unfairly and callously, use the very low percentage of enrollment in this very important national program to offset our valid concerns about the Federal deficit.

But as Mr. Kostmayer said, this program was authorized. These low-income, needy, and deserving seniors have every right to it. It is very cruel, I think, to have what is, in effect, an entitlement program disguised as a discretionary program. And I know with the alertness and the concern of this committee, there is a good chance one way or another to have this rectified.

And I thank you very much and stand open to any questions or concerns you want to raise.

[The prepared statement follows:]

Statement of Frank McCloskey
Subcommittee on Social Security, Human Resources,
and, Health
Hearing on the Qualified Medicare Beneficiary Program
March 26, 1992

MR. CHAIRMAN, IN 1990, POOR SENIOR AND DISABLED CITIZENS SPENT OVER \$790 MILLION FOR MEDICARE BUY-IN BENEFITS ENTITLED TO THEM BY CONGRESS. THE QUALIFIED MEDICARE BENEFICIARIES PROGRAM (QMB) CREATED BY THE ILL-FATED MEDICARE CATASTROPHIC ACT OF 1988, REQUIRED STATE MEDICAID AGENCIES TO PAY FOR THE SUBSTANTIAL OUT-OF-POCKET COSTS OF MEDICARE. THIS WAS AN EXCELLENT POLICY DECISION AND ONE THAT POOR SENIORS, FACING MEDICARE BILLS OVER \$1,000 PER YEAR, DESPERATELY NEEDED. HOWEVER, THIS PROGRAM HAS BEEN KEPT A VIRTUAL SECRET BY THE GOVERNMENT IN A CALLOUS ATTEMPT TO KEEP OUR INCREASING BUDGET DEFICIT DOWN. WHILE THE PRESIDENT VETOES A TAX BREAK DESIGNED TO ASSIST THE STRUGGLING MIDDLE CLASS, THERE HAS BEEN ONLY TOKEN ATTEMPTS BY THE EXECUTIVE BRANCH TO PUBLICIZE THE QIMBY PROGRAM AND ENSURE THAT LOW-INCOME SENIORS AND DISABLED CITIZENS RECEIVE THE HEALTH BENEFITS THEY CAN NOT OTHERWISE AFFORD.

MR. CHAIRMAN, THE PROBLEM WITH QMB IS THAT NO ONE KNOWS IT EXISTS. ACCORDING TO FAMILIES USA, IN THEIR TWO HARD-HITTING REPORTS, CLOSE TO HALF OF THE 4.5 MILLION CITIZENS ELIGIBLE FOR QMB BENEFITS ARE NOT ENROLLED. WHAT THIS MEANS IS THAT OVER 2 MILLION DISABLED AND SENIOR CITIZENS ARE PAYING \$381.60 A YEAR IN MEDICARE PART B PREMIUM CHARGES THEY DO NOT OWE. WHAT'S WORSE IS IF THESE PEOPLE HAVE TO GO TO THE HOSPITAL, WHICH IS A VERY LIKELY OCCURRENCE, THE COST FOR THE PART A PREMIUM IS OVER \$650. IN OTHER WORDS, THESE LOW-INCOME PEOPLE COULD PAY WELL OVER \$1,000 FOR MEDICAL CARE THEY ARE ENTITLED TO RECEIVE FREE. THIS IS SIMPLY UNACCEPTABLE.

I HAVE INTRODUCED TWO BILLS WHICH DEAL WITH THIS PROBLEM, H.R. 2855 AND H.R. 3649. IT IS MY HOPE THAT THE SUBCOMMITTEE WILL CONSIDER THE MERITS OF BOTH BILLS WHEN DEVISING A SOLUTION TO THIS PROBLEM.

AS I PREVIOUSLY SAID, THE PROBLEM IS THAT FEW PEOPLE KNOW ABOUT QMB. ONE OF THE REASONS IS THE DEPARTMENT OF HEALTH AND HUMANS SERVICES' REFUSAL TO CARRY ON ANY SORT OF REAL OUTREACH EFFORTS TO INFORM THOSE WHO MIGHT BE ELIGIBLE. THE HHS OPPOSES THE USE OF PROVIDERS TO DISSEMINATE QMB INFORMATION AND REFUSES TO LET CITIZENS APPLY FOR QMB AT THEIR LOCAL SOCIAL SECURITY AGENCY. ALSO, HHS DOES NOT MENTION THE QMB PROGRAM IN THE 1992 GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE UNTIL PAGE 19. WHAT'S MORE, THIS BOOKLET IS ONLY AVAILABLE TO MEDICARE RECIPIENTS BY REQUEST; DOES THIS INDICATE TO YOU A COMMITMENT TO REACHING OUT TO ALL THOSE ELIGIBLE FOR QMB? I DON'T THINK SO EITHER.

MANY OF THE BILLS BEING CONSIDERED TODAY MANDATE OUTREACH PROGRAMS. THIS IS A NECESSARY STEP IN LOCATING AND ENROLLING ELIGIBLE PERSONS IN QMB AND MY 2ND BILL CONTAINS MANY OF THESE OUTREACH PROVISIONS. HOWEVER, IF WE WANT TO GET QMB TO WORK THE WAY IT WAS INTENDED, THERE IS ONLY ONE SOLUTION TO THE PROBLEM; REQUIRE THE SSA TO MAKE QMB DETERMINATIONS WHEN INDIVIDUALS SIGN UP FOR MEDICARE; THIS IS THE HEART OF MY FIRST BILL, H.R. 2855. I KNOW THE SSA AND THE SUBCOMMITTEE ON SOCIAL SECURITY ARE NOT IN FAVOR OF THIS LEGISLATION. I HOPE TO HOWEVER, POINT OUT THE OVERWHELMING ADVANTAGES THIS LEGISLATION OFFERS AND ADDRESS THE CONCERNS OF THE SUBCOMMITTEE AND THE SSA AS WELL.

BECAUSE OF ITS EXPERIENCE WITH THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM, WHICH UNLIKE QMB IS FANTASTICALLY SUCCESSFUL, THE SOCIAL SECURITY ADMINISTRATION IS ACCUSTOMED TO DETERMINING THE INCOME LEVELS OF ITS CLIENTS. IT MAKES PERFECT SENSE FOR THE SSA TO MAKE THESE INCOME DETERMINATIONS FOR THE QMB PROGRAM WHEN INDIVIDUALS SIGN-UP FOR MEDICARE. ALMOST ALL SENIORS APPLY BY PHONE OR IN PERSON TO ENROLL IN MEDICARE. THE SSA OFFICIAL PROCESSING THE APPLICATION NEED ONLY ASK CERTAIN QUESTIONS TO DETERMINE IF THE INDIVIDUAL MAY BE ELIGIBLE FOR QMB. THIS IS STANDARD OPERATING PROCEDURE WHEN DEALING WITH A POTENTIAL SSI RECIPIENT. ADDITIONALLY, THE SSA ALREADY HAS COMPUTER PROGRAMS DESIGNED TO HANDLE INCOME QUESTIONS FOR SSI AND IT WOULD BE A SIMPLE MATTER TO PROGRAM THEM TO INCLUDE QMB INFORMATION AS WELL.

THIS IS THE ONLY WAY TO ENSURE THAT EVERY QMB PERSON IS ENROLLED. MY BILL DOES NOT MANDATE THE UNEARTHING OF THOSE PERSONS WHO HAVE ALREADY BEEN PASSED OVER, MERELY, IT ENSURES THAT FROM NOW ON, THOSE WHO ARE ELIGIBLE FOR QMB, WILL BE ENROLLED. MR. CHAIRMAN, THE REASON WHY SSI WORKS SO WELL IS BECAUSE THE SSA IS COMMITTED TO SERVING EVERY SSI RECIPIENT IN THE COUNTRY. I AM ASKING THAT THE SSA PUT THAT SAME COMMITMENT AND EFFICIENCY INTO SERVING EVERY QMB PERSON, AS WELL.

I UNDERSTAND THE CONCERNS OF THE SUBCOMMITTEE REGARDING MY BILL. LACK OF STAFF IS ALREADY DEBILITATING THE SSA, DISABILITY CLAIMS ARE FALLING FURTHER BEHIND, AND THERE IS NOT ENOUGH FUNDING TO GO AROUND. I DO NOT BELIEVE THAT REQUIRING SSA TO MAKE ELIGIBILITY DETERMINATIONS WILL PROVE TO BE UNDULY BURDENSOME. AND REALLY, THAT IS NOT THE POINT OF THIS HEARING ANY WAY. QMB IS MANDATED BY AN ACT OF CONGRESS. THESE LOW-INCOME CITIZENS DESERVE THE BENEFITS THEY ARE ENTITLED TO BY LAW. THEY CAN NOT BE ASKED TO SPEND OVER 1/6 OF THEIR ANNUAL EARNINGS ON MEDICAL CARE. MR. CHAIRMAN, ADMINISTRATIVE INTRANSIGENCE IS NOT AN EXCUSE FOR NOT DOING ONE'S JOB.

FINALLY, I DO NOT INTEND TO TAKE ONE CENT AWAY FROM THE SSA; INDEED, I HAVE ALWAYS PUSHED FOR ITS INCREASED FUNDING. FOR FY93, THE HCFA ADMINISTRATIVE BUDGET ALLOCATES OVER \$659 MILLION TO THE SSA FOR THE SERVICES IT RENDERS. MY BILL WOULD BE FINANCED THROUGH THIS ACCOUNT. THE CONGRESSIONAL BUDGET OFFICE ESTIMATES THAT THE ADMINISTRATIVE COSTS OF H.R. 2855 WOULD BE APPROXIMATELY \$18 MILLION NEXT YEAR. IN ACTUALITY, HOWEVER, H.R. 2855 WILL SAVE MONEY. IT WILL BE FAR CHEAPER TO SIGN UP QMB PERSONS AT THE AGE OF 65, INSTEAD OF HAVING TO SPAN THE COUNTRY LOOKING FOR THOSE WE MAY HAVE MISSED. OUTREACH EFFORTS, THOUGH CURRENTLY NECESSARY, WILL COST US FAR MORE IF WE CONTINUE TO RELY SOLELY ON THEM. MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU TODAY.

Chairman JACOBS. Thank you, Mr. McCloskey.

Mr. Bunning.

Mr. BUNNING. Let me ask you, is the Federal Government required to fund the total program? Doesn't the State have some responsibility as far as funding is concerned?

Mr. McCLOSKEY. Well, obviously the State administers Medicaid, and this is Medicaid money and Medicaid administered, but as I understand it—and correct me, if I am wrong, Mr. Chairman—it is basically a function of Federal and State dollars. Obviously there could be some State administrative concerns.

Mr. Bunning, I would also note that in Indiana before this issue was raised, 80 percent of the people eligible for QMB, as Mr. Jacobs knows, were not enrolled. Now we have improved to the point where 65 percent of those eligible are not enrolled.

But why have seniors, facing thousands of dollars in medical bills that we have said can be picked up by Medicaid, suffered this imposition when they are at the lowest end of the income ladder?

Mr. BUNNING. What I am trying to find out is, in Indiana, as in Kentucky, there is a State match for Medicaid.

Mr. McCLOSKEY. Quite frankly, I do not know the details on that State match. I will try to get that for you, Mr. Bunning, for the record. Perhaps Mr. Jacobs knows.

Mr. BUNNING. OK, thank you. That is what I wanted to find out.

Chairman JACOBS. All right. Mr. Downey will ask questions.

Mr. DOWNEY. Mr. Chairman, I do not have any questions.

Of course, there is a State match for Medicaid. It is based on the square of the State per capita income divided by the square of the Federal per capital income. It is the same for Medicaid as it is for AFDC and for foster care.

Mr. McCLOSKEY. I did not know that, Mr. Downey. Thank you.

Mr. DOWNEY. It is a particularly useless bit of information, I would point out.

In any event, there are States around the country that have done an excellent job of reaching out to people and making sure that this is done.

Mr. Bunning raises an interesting point, that the States have some obligation, if they so choose, to play a bigger role. They should play a bigger role in outreach.

But this is principally a national responsibility.

Mr. McCLOSKEY. Right.

Mr. DOWNEY. And that is really where our focus should be. The States could make sure that many more people are eligible for SSI, and many more people would be eligible.

Mr. McCLOSKEY. I know I do not have to tell you the burdens that are coming down on States as to Medicaid funding and other areas, and obviously that is a concern.

I might also say that the second version of my bill, cosponsored also by Mr. Rahall, calls for retroactive payments for people who have paid these bills over the last 2 years.

Quite frankly, retroactive payments would be wonderful, but we would also be talking about a total cost, Mr. Chairman, of about \$1.5 billion.

But I did want to make that clear. The main concern would be that hopefully we correct it from here on.

Chairman JACOBS. Thank you for your contribution to the record, Mr. McCloskey.

Mr. McCLOSKEY. Thank you.

Chairman JACOBS. Our next witness is a member of both the subcommittee and therefore the full committee, Mr. Jim Moody, a Representative in Congress from the State of Wisconsin.

**STATEMENT OF HON. JIM MOODY, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF WISCONSIN**

Mr. MOODY. Thank you, Mr. Chairman, and it is good to be back in my old subcommittee.

Thank you for holding this review of outreach efforts for QMB. I think it is clear that much needs to be done. When you look at the numbers of people who are not availing themselves of QMB, you realize that we are clearly falling down.

I would like to bring to the committee's attention legislation that I and 79 other cosponsors are supporting, H.R. 3473. It is also supported by groups like Families USA, the National Council for Senior Citizens, and others.

This, of course, is not a new program. It has been the law since 1988. Yet only 50 percent of eligible beneficiaries actually end up using it. The legislation that 80 of us are supporting would at last put teeth into the QMB Program.

As you know, the QMB law requires that the premiums, copayments, and deductibles for Medicare recipients be covered if they have annual incomes below the Federal poverty level, which is, \$6,810 for an individual, and assets must be below \$4,000. Obviously, couples have a slightly higher level.

It does not take very much arithmetic to determine that \$31.80 per month, plus a \$100 deductible for physician services, plus 20 percent copayments, plus \$652 hospital deductibles, Mr. Chairman, which is probably well over \$1,000 can prove disastrous when you add it all up. It is disastrous for someone who is receiving \$6,800 a year. You are taking one-sixth of their income away from them for an expense they have no basic control over. Yet 50 percent of those hardpressed, below-poverty-line senior citizens are not availing themselves of the QMB benefit, and the studies show, by Families USA and others, it is basically because seniors don't know about it, or they are inhibited because of the way it is structured.

Many States, most States—mine is not one of them, fortunately—require QMB applicants to go to the welfare office to apply. Well, in my district, this carries with it a substantial stigma. Fortunately, in Wisconsin, you go to the human services office; you do not go to the welfare office. But in an overwhelming number of States, you are required to go to the welfare office to apply for a benefit which has nothing to do with welfare. This is, itself, extremely inhibiting.

I think we have to basically force the administration to begin to implement this law, having given them 4 years to do so and having the failure rate still at 50 percent. This is a D-minus or an F by any scorecard. It is time for us to now step in with legislation and require that these steps be taken to enforce existing law. This is not new law that we are suggesting.

In townhall meetings that I have had in my district, and I suppose everyone of us in this room, we have heard the horror stories of dealing with today's health system in meeting the costs. The QMB Program, which is surgically targeted—it is precise; it's not another broad-based entitlement that affects people regardless of income; it's one of the most targeted programs we can imagine, and we should make it work.

The five provisions of the bill that I am supporting and that should be done without the bill, but apparently are not being, are: First, to require HHS to include a clear—and let me emphasize "clear," because the gobbledygook we have seen is not intelligible to many senior citizens—a clear and a brief description of the program. It is not a complicated program.

But to read the bureaucratic language, you would think it was an extremely complicated program, and it is lengthy, and it does not need to be. We should require that it be put into readable English and not bureaucratise. That's No. 1, a brief description of the program, and should be put in every year's Medicare notice, not only in the handbook which is a lengthy document which many seniors never read. It is in the handbook. It should be put in simple language in the yearly Medicare notice mailing, No. 1. That should be easy to do.

No. 2, we should allow seniors to obtain applications and return completed ones to local Social Security offices. Mr. Chairman, I would suggest that these are returned to the Social Security office rather than to the welfare office. Everybody would be better off.

No. 3, we should expand public awareness efforts across the board.

No. 4, we should provide the States the option of allowing poor seniors to, quote, spend down, unquote—that is, deduct their incurred medical expenses in order to reach the QMB income level. That is obviously important.

And No. 5, we should, in my judgment—and this is probably the one controversial part of the bill I am supporting—implement some limited retroactive provisions, so that eligible seniors who were denied the benefit for lack of information are partially compensated at this time.

This bill does not make new policy for low-income seniors. The policy has already been adopted by the Congress and signed by the President, who was sworn to uphold the policies that he signs.

But the reality is that there are 2 million—2 million—senior citizens out there who are not benefiting, who should be and could be.

The Congress opened the door to health care for these particularly needy seniors, but the administration has apparently blocked the entrance or at least not removed all the obstacles that they could have removed.

Four years of inaction is now enough. It is time for Congress to pass legislation to ensure that our intentions of 1988 are finally implemented. I hope this committee, this subcommittee, will support H.R. 3473, and I look forward to working with you to bring that bill to reality.

[The prepared statement follows:]

JIM MOODY
WISCONSIN

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Statement of Congressman Jim Moody
The Qualified Medicare Beneficiary Program
March 26, 1992

First, I would like to thank the Chairmen of the three subcommittees gathered here today to review the outreach efforts for the Qualified Medicare Beneficiary Program and the Supplemental Security Income Program. Much needs to be done to improve participation in these vital programs and the simple action of this hearing may help raise public awareness. Every step helps.

Specifically, I am here today to bring to the attention of the committee legislation I introduced last year to improve the QMB program. My bill, HR 3473, now has 79 cosponsors and is supported by both Families USA and the National Council of Senior Citizens. Rep. Kostmayer, who you will hear from next, is a co-author of this legislation.

The Qualified Medicare Beneficiary Program is not a new program; it became law in 1988. Yet, it is estimated that 50% of eligible beneficiaries (2 million seniors) do not know the benefit exists.

HR 3473 will put teeth into the QMB program. QMB law requires Medicaid to cover the premiums, copayments and deductibles for low-income Medicare seniors with annual incomes below the federal poverty level (\$6,810) and with assets below \$4,000. (Couples must have assets below \$6,000 and income less than \$9,190.)

It doesn't take much arithmetic to determine that the \$31.80 per month premium, plus \$100 deductible for physician services, plus 20% copayments, and the \$652 hospital deductible can prove onerous -- even financially devastating -- for a senior with an income below \$6810. This is another case of government squeezing the people who can least afford it.

Why are eligible seniors not participating in the QMB program? The answer to that question is that many of them do not even know the program exists. If they have heard of it, states often require that a senior go to the state welfare office to apply for it. The social stigma of such action prevents many seniors who have worked all of their lives, and paid into the Medicare program, from seeking assistance at the state welfare office.

Back in July of 1991, a number of us from the Health Subcommittee wrote HHS to urge them to remedy this information gap. Unfortunately, we have seen few changes.

We must fight to force the Administration's hand if we wish the translate the law to help low-income seniors into reality. HHS's promises to publicize the program have proven empty. We must act legislatively to require HHS to make this program widely understood among seniors and remove the current barriers to application. And we must reach back to make some partial reparation for the lack of effort shown so far.

Throughout my town meetings in Wisconsin, I have heard horror stories from my constituents about their dealings with today's health care system. The QMB program is something that can immediately help a low-income senior make ends meet. If only they knew it existed and could easily apply.

The main provisions of our bill would:

- (1) require HHS to include a brief description of the program, and a preliminary application, in the yearly Medicare notice,
- (2) allow seniors to obtain applications and return completed ones to the local Social Security Office,
- (3) expand public awareness efforts,
- (4) provide states the option of allowing poor seniors to "spend down" (deduct their incurred medical expenses) to reach the QMB income level, and
- (5) implement a limited retroactive provision so that eligible seniors who were denied benefits for lack information get partially compensated.

This bill does not make new policy for low-income seniors. The policy has already been declared. We simply make this policy a reality for the two million eligible seniors who are still unaware of the benefits. The Congress opened the door to health care for these particularly needy seniors, but the Administration has blocked the entrance. Four years of inaction are enough, its time for Congress to pass legislation ensuring that our intentions are carried through. I hope you will join me in support of HR 3473 and look forward to working together to correct this ongoing inequity.

HR 3473
THE QUALIFIED MEDICARE BENEFICIARY ENROLLMENT AND IMPROVEMENT ACT
Bill Summary

1. REQUIRE DESCRIPTION OF MEDICARE COST-SHARING PROTECTION IN ANNUAL NOTICE SENT TO MEDICARE BENEFICIARIES:

Each year Medicare sends a notice to Medicare beneficiaries. Our bill would require HHS to include a clear, simple explanation of the QMB program and how to apply for the benefit in this notice. Such explanation would also include any changes in eligibility requirements from the previous year and include the phone number for the consumer toll-free hotline (described below). A preliminary QMB application would also be included.

2. PUBLICIZING THE QMB PROGRAM

To increase public awareness of the QMB program, HHS would develop a poster describing the program. This poster would be distributed to hospitals, physicians, and other health care providers for display in their offices. The posters would also be given to community groups active with senior citizens.

TOLL FREE HOTLINE -- Establish a toll free number for beneficiaries to obtain information on the QMB program.

3. USE OF SOCIAL SECURITY OFFICES FOR RECEIPT OF APPLICATIONS FOR QMB PROGRAM

Part of the current stigma preventing seniors from even applying for the QMB benefits is that they are required to go to a state welfare office to apply. Our bill would require that states establish a process for distribution and receipt of applications for the program at the Social Security office. In addition, personnel of such offices shall be trained to assist with the completion of the application form. The Social Security office would then transfer the application to the appropriate state office for processing.

DISTRIBUTION FORM FOR AN APPLICATION: The Secretary shall also develop a form that contains a clear description of the QMB benefit in English (and other languages as appropriate). This form must include a pre-addressed reply card that an individual may mail to the agency administering the state program to receive an application and additional information on the program. This form will also be made available to community groups participating in programs designed to provide services to senior citizens. The state would be required to respond by mail to these requests within 30 days upon receipt.

4. ELIGIBILITY:

When a person is determined to be eligible for QMB benefits, such eligibility will be considered valid for 12 months from the date of application.

In addition, the benefits will retroactively cover three months prior to application. This would be identical to Medicaid.

5. RETROACTIVITY:

Individuals who apply for the QMB benefit who were entitled to the benefit in 1991, but did not receive it would be retroactively reimbursed for those benefits -- if they apply during the first year of this law being in effect.

6. OPTIONAL SPENDDOWN

Under current law, while Medicaid recipients are allowed to spenddown in states that choose to provide that option -- deduct their Medical expenses from their income to meet the Medicaid income requirements -- QMBs cannot spenddown. This section would simply allow them to do so, but only for incurred portions of their medical bills.

7. GRANTS FOR OUTREACH:

A grant program will be developed to groups who establish and operate an information, counseling, and assistance program to help people who may be eligible for QMB benefits to understand and apply for the program.

Grants will be split with 50% going to states and 50% to community groups active with seniors. Such funds would be used for programs to provide information on the QMB program and assistance with applications -- the funds could not supplant current funds expended for such efforts.

Funding levels: In equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, \$30,000,000 for FY 1992-94 and \$10,000,000 for later years.

The Qualified Medicare Beneficiary Enrollment and Improvement Act
HR 3473

ORIGINAL COSPONSORS:

1. Jim Moody (WI)
2. Peter Kostmayer (PA)
3. Jim McDermott (WA)
4. Gerry Studds (MA)
5. Edward Roybal (CA)
6. William Coyne (PA)
7. Brian Donnelly (MA)
8. Sander Levin (MI)
9. Tom Bevill (AL)
10. Jack Reed (RI)
11. Barney Frank (MA)
12. Martin Sabo (MN)
13. Nancy Pelosi (CA)
14. Dante Fascell ((FL)
15. Frank Guarini (NJ)
16. Frank Horton (NY)
17. Tom Manton (NY)
18. James Bilbray (NV)
19. Mike Synar (OK)
20. Jim Oberstar (MN)
21. Mary Rose Oskar (OH)
22. Jim Jontz (IN)
23. Les AuCoin (OR)
24. Edolphus Towns (NY)
25. Marilyn Lloyd (TN)
26. Julian Dixon (CA)
27. Lane Evans (IL)
28. Paul Kanjorski (PA)
29. Gary Ackerman (NY)
30. Dale Kildee (MI)
31. Wayne Owens (UT)
32. John Bryant (TX)
33. Al McCandless (CA)
34. John Tanner (TN)
35. Robert Borski (PA)
36. Kweisi Mfume (MD)
37. Tony Hall (OH)

Additional Cosponsors:

38. Esteban Torres (CA)
39. Ron Dellums (CA)
40. Ron Wyden (OR)
41. Robert Roe (NJ)
42. Bill Jefferson (LA)
43. Charles Taylor (NC)
44. E. Holmes Norton (DC)
45. Peter DeFazio (OR)
46. Mike Kopetski (OR)
47. Pat Williams (MT)
48. Jolene Unsoeld (WA)
49. Bill Hughes (NJ)
50. Robert Lagomarsino (CA)
51. Mel Levine (CA)
52. Austin Murphy (PA)
53. Sid Yates (IL)
54. G. Hochbrueckner (NY)
55. Bruce Vento (MN)
56. Major Owens (MN)
57. Floyd Flake (NY)
58. Glenn Poshard (IL)
59. Charles Hayes (IL)
60. Matthew Martinez (CA)
61. Ed Markey (MA)
62. John LaFalce (NY)
63. Ben Erdreich (AL)
64. Richard Neal (MA)
65. Martin Frost (TX)
66. Bernard Dwyer (NJ)
67. Richard Stallings (ID)
68. Al Swift (WI)
69. John Conyers (MI)
70. Howard Berman (CA)
71. Joe Kolter (PA)
72. Chet Atkins (MA)
73. Jim Scheuer (NY)
74. Ted Weiss (NY)
75. Joan Kelly Horn (MO)
76. Charles Wilson (TX)
77. William Jefferson (LA)
78. Tim Valentine (NC)
79. Charles Rangel (NY)
80. Tom Downey (NY)

Chairman JACOBS. As you are a member of the Health Subcommittee, it is very likely that you will do what you look forward to doing.

Mr. Downey.

Mr. DOWNEY. I have no questions. He is also, Mr. Chairman, a member of my subcommittee as well, so we are doubly blessed.

Chairman JACOBS. Well, he obviously has the talent to take on the duties.

Mr. MOODY. Thank you.

Chairman JACOBS. Mr. Bunning thinks you are talented, too.

Mr. DOWNEY. It is unanimous.

Chairman JACOBS. The next testimony will come from a panel consisting of the Social Security Administration guru, Louis Enoff, and the Health Care Financing Administration, Director of the Medicaid Program, Christine Nye.

Mr. Enoff, you may proceed in your own manner and take as much time as you wish up to 5 minutes.

STATEMENT OF HON. LOUIS D. ENOFF, PRINCIPAL DEPUTY COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

Mr. ENOFF. Thank you.

Chairman Jacobs, Chairman Downey, Mr. Bunning, I appreciate this opportunity to join you on Commissioner King's behalf this morning to discuss one of our most critical priorities; that is, outreach to those who are in need of and are entitled to assistance from the programs that SSA administers.

I would like to submit my full statement for the record and make a few brief opening remarks with your permission.

Chairman JACOBS. Without objection.

Mr. ENOFF. Our efforts to reach out to more of those in America who need help—men, women, and children who have disabilities, people who are elderly and infirm, people who are homeless, people who are eligible for assistance but have not sought it—our efforts to find and assist people in need have been intense, varied, and innovative. And it should be made clear that they have been working.

We have strong indications that our outreach efforts have been successful. We continue to see a rise in the overall number of applications and awards for supplemental security income. For example, the number of SSI applications received during the first 3 months of fiscal year 1992 is up by 39.8 percent over the first 3 months of fiscal year 1990, when our increased outreach efforts began. During the same period, awards went up by 42.8 percent.

A major reason for this success is a coordinated outreach campaign that takes place on several fronts. Our activities range from grassroots efforts performed by our field office employees throughout the country to national public information campaigns, to cooperative ventures with other public and private sector entities, to innovative demonstration projects aimed at finding new and better ways of reaching out to people in need.

On a national level, we have printed and distributed millions of pamphlets and factsheets on SSI from our 1,300 field offices throughout the country. We have produced radio and television

public service announcements and articles for newspaper publication. We have designed flyers and posters for use in senior centers, homeless shelters, and other sites where we can reach potential beneficiaries.

And as you know, we provide program information to congressional offices, which you and your colleagues have used in your own communications with constituents. We have worked with Congress in producing joint public service announcements.

These are conventional means of outreach, and they have been effective. But we have gone beyond the conventional and utilized the innovative.

With congressionally appropriated funds, we have engaged in 33 cooperative agreements with organizations throughout the country and expect to launch another 40 this fiscal year. With these projects, we are testing new methods of outreach to a wide variety of specific populations: Urban and rural elderly, the homeless, native Americans, low-income African-Americans, mentally ill adults, people with AIDS, and others.

With our appropriated outreach funds, we are also funding inter-agency efforts with the Department of Veterans Affairs to provide services to homeless veterans and with the Indian Health Service to test ways to reach homeless native Americans.

There are three important principles at work in our joint efforts with other private and public organizations. The first is that we do not have all of the answers at the Social Security Administration. We can make this program more effective by seeking a broad range of expertise and ideas from inside and outside of Government.

The second principle is the need to create a lasting outreach mechanism. We want to establish relationships with other groups and organizations that will result in a permanent outreach effort, not one that will change or lapse from Commissioner to Commissioner or administration to administration.

The third principle is our belief that outreach becomes more effective if it involves the individuals, groups, and organizations that work with vulnerable Americans every day. We have found that our message can be communicated far more effectively by someone who has already established a relationship with the potential beneficiary. People are far more likely to walk through a door held open by a familiar face than by a stranger with a Government ID card.

In the weeks and months ahead, outreach will continue to be a major priority at the Social Security Administration. Special emphasis will be given to specific populations that have been very difficult for us to reach in the past, such as disabled children, people who are homeless, and people with AIDS or HIV infection.

Our efforts toward children with disabilities have been quite effective. Childhood applications for SSI have increased by about 250 percent since 1989, and we are making great progress in processing our cases stemming from the Supreme Court's *Zebley* decision.

Last July, we mailed notices to over 452,000 children affected by the *Zebley* decision. Since then, approximately 208,000 persons have claimed *Zebley* class status, and to date we have completed about 54,000 *Zebley* cases, of which more than 60 percent have been allowed benefits.

To reach homeless individuals, we have appointed homeless coordinators for more than 1,000 SSA field offices nationwide to serve as liaison between SSA and the community organizations and providers who work daily with homeless persons. These connections have borne fruit. In Baltimore, for example, SSA employees and city, State, and private-sector service providers have literally hit the streets to bring information and a variety of valuable services to people without homes.

We have launched several pilot projects sponsored by AIDS advocacy groups aimed at recruiting volunteers to serve as representative payees for people with HIV infection who need help handling their financial affairs. And we have begun a public awareness campaign alerting people who have tested HIV-positive to check their Social Security earnings records to ensure speedy claims processing if they need to file for disability in the future.

I wish I had more time to discuss at length the many other outreach activities we are utilizing to assist these and other hard-to-reach segments of the populace. My written statement does go into more detail on a variety of these activities.

I have told you this morning of our success in outreach and the reasons we have been successful. I do not want to leave the impression, however, that we are complacent or satisfied with our performance to date. There are still many Americans who are living lives of despair, people who are eligible for assistance that could make a critical difference in their lives.

We cannot be satisfied as long as there are people out there who need our help and are not getting it. We will continue to strive to develop new ways to locate men, women, and children who need and are eligible for Social Security or supplemental security income assistance.

We look forward to working with your subcommittees to make our program as effective as it can possibly be.

With that, I will yield to Ms. Nye or answer questions.

[The prepared statement follows:]

TESTIMONY OF LOUIS D. ENOFF, PRINCIPAL DEPUTY COMMISSIONER
SOCIAL SECURITY ADMINISTRATION

Chairman Jacobs, Chairman Downey, Chairman Stark, and members of the Subcommittees:

I am pleased to be here today on behalf of Commissioner King to discuss SSA's outreach efforts. Commissioner King and I are strongly committed to ensuring that SSA provides the best possible service to the public. A critical part of that commitment is to ensure that we fully inform the public about the programs we administer and that ultimately we achieve full participation in SSA's programs for those members of the public who desire to participate.

This is, of course, not an easy task. Often, those Americans who are most in need--including children with disabilities, the elderly, and those who are so poor that they have no home--are also the most difficult for us to reach. And they are often the least able to cope with government bureaucracies. So we have a special responsibility to help them.

Recognizing this, I would like to share with you information about the kinds of activities SSA conducts in "reaching out" to our citizens in order to inform eligible people about the SSI program.

SSI Outreach

Our SSI outreach efforts range from those designed to have impact nationwide to grassroots activities performed by our local office employees. They include cooperative ventures with other governmental agencies and private sector groups as well as those conducted solely by SSA. We are also using research money to learn what are the most efficient, effective, and transferable methods of conducting outreach.

SSA National Efforts

SSA has a vigorous outreach effort at the national level. Let me first address those things which SSA does on its own. For example, we print millions of copies of informational pamphlets and factsheets on SSI. These public information materials are distributed through our own offices as well as through outside organizations.

We also issue public service announcements for radio and TV and distribute articles with SSI information, which are reprinted by newspapers around the country. We design and print posters, fliers, and other items that can be displayed at locations--such as senior centers--where SSI-eligible people may congregate.

We also maintain liaison with the national headquarters of many outside groups who help us disseminate information about SSI. Our contacts include civic volunteer organizations, interest groups, professional associations, and so on.

As you know, we also send information to congressional offices. We work with many Members of Congress in distributing information about Social Security programs--including SSI--for example, in their mailings to constituents or in their TV and radio spots. SSA and Members of Congress have also cooperated in the development of joint public service announcements. For example, Mr. Cardin and SSA produced an announcement on children with disabilities and the Zebley court decision that aired frequently in Maryland.

National Strategy Using Demonstration Projects

To identify and investigate new ideas, we often find it helpful to use "demonstration projects." These projects help us to focus our efforts on what works best by giving us a chance to test innovative ideas on a small scale.

As you know, Congress has given SSA special funding for SSI outreach to allow us to award cooperative agreements to outside organizations and to fund work with other Federal agencies so that we can test effective, efficient, ongoing, and transferable approaches to doing outreach.

Thirty-three grantees from around the Nation were selected in response to a 1990 Federal Register announcement. The projects were targeted to a wide variety of populations including urban and rural elderly, persons with disabilities (including people with AIDS), the homeless, and minority and ethnic communities.

For example, one grantee has tested the effectiveness of Federal and State agencies and local area networks of public and private service providers in doing outreach to Native Americans and Hispanics in the State of Arizona. The project developed a referral system allowing for one-on-one assistance by volunteers.

Another grantee is focusing on helping frail and/or homebound elderly and disabled individuals--primarily African Americans--in East St. Louis, Illinois. The grantee tested the use of a "mobile office" to make door-to-door contacts.

Families USA Foundation was also a grantee and conducted SSI outreach in western Massachusetts from October, 1990, through December, 1991. Under the project, three elders' services organizations and two centers for independent living screened their records for clients who might meet SSI eligibility requirements. In addition, activities included presentations before local service and advocacy groups, a public information campaign through the local media, door-to-door canvassing, and one-on-one assistance in filing applications.

In September 1991, we published our second announcement of demonstration projects in the Federal Register. Before issuing that announcement, we analyzed the types of projects covered by the first set of grantees to help ensure that the second group of projects would not overlap the efforts of the first group.

The second announcement specifically emphasized our interest in projects to reach low-income African Americans, Native Americans, mentally ill adults, children with disabilities, the homeless, and others, including people with AIDS. The 464 applications we received are currently under review. We expect to award approximately 40 cooperative agreements this fiscal year.

We take our research responsibilities very seriously. That is why we awarded an evaluation contract to assess the results of the outreach projects. The results of the first 33 projects will be evaluated by April 1994. (However, a first-phase evaluation, of 12 projects from the first announcement, will be completed by October 1992.) The results of this evaluation will help us develop effective new outreach projects and determine which current ones should be implemented nationally.

Cooperation with Other Federal Agencies

In addition to conducting outreach demonstration projects through grants to organizations, we also work with Executive Branch agencies. Some of our current interagency ventures are as follows.

- o We and the VA (Department of Veterans Affairs) are conducting a demonstration project to provide integrated services to veterans. Under this arrangement, SSA and the VA are coordinating services in the approximately 75 cities where VA operates programs specifically designed to assist homeless veterans. For example, in

New York and Dallas, SSA and State DDS employees are taking applications for SSI benefits at sites where people come to get VA services.

This makes things easier for the veteran, and expedites SSI claims processing because it makes it possible for us to get more complete medical information from the VA faster and at a lower cost.

- o SSA has actively participated in the development of the Report of the Task Force on Homelessness and Severe Mental Illness which Secretaries Kemp and Sullivan released last Friday. The Report, Outcasts on Main Street, identifies ways to make Federal, State, and local programs more accessible to homeless individuals who have mental illnesses. HHS and HUD have already announced a demonstration program to test the recommendations. SSA will be a full participant.
- o SSA is working with the Indian Health Service (IHS), in another demonstration project, to develop and test ways to reach Native Americans. We utilized research funds in working with IHS to enlist Native American contractors for this project. Two contractors have developed and are now testing models that support SSA outreach efforts for reservation and urban populations, working through health care providers.

Efforts at the Local Level

Now I would like to discuss some of the most interesting and exciting examples of outreach activities--those done at the grassroots level by SSA employees in local field offices. These grassroots efforts have been one of Commissioner King's top priorities. This is reflected in the fact that, in February 1990, the Commissioner issued "Principles of SSI Outreach" to all SSA Regional Commissioners.

The Principles outline a basic strategy for outreach efforts. This strategy requires SSA field personnel to "link up" with a variety of groups and organizations that can identify and reach people whom we cannot. In essence, this link-up at the grassroots level parallels the link-up we make at the national level with other governmental agencies and national organizations.

The strategy recognizes that SSA--working alone--would never have the ability to reach all the individuals who are helped through cooperative outreach efforts. In addition to assisting SSA with an important workload, the approach called for in the Principles also means that people are "helped through the door" by someone (often, a volunteer) whom they know and trust.

The principles ensure that outreach efforts are being made in every service area across the Nation. They are based on information from many sources, such as studies on SSI participation and reports of barriers to participation (including language and transportation difficulties and the stigma sometimes associated with receiving SSI). The Principles also reflect consultation with private organizations, other agencies, and our own employees.

Some Recent Successes

Rather than talking in the abstract, though, I would like to tell you about a few of our many successful local outreach projects based on these Principles:

- o Two of the most successful efforts to date have been contacts by our Atlanta Regional Office with State food stamp offices and by the New York Regional Office with State food stamp, Medicaid, Pharmaceutical, Lifeline, and home energy assistance program offices. Our regional offices obtained computer listings of people potentially eligible for SSI. We then mailed information about the SSI program to the people on the lists, requesting that those who think they might be eligible contact SSA. As a result, we have awarded SSI benefits to thousands of people who were eligible but had not been receiving them. We will be conducting similar matching programs on a national level.
- o In Dallas, Texas, SSA is a member of a local coalition of social service providers. Social workers in member agencies answer questions about SSI, screen individuals for eligibility, and refer potentially eligible individuals to the local field offices. Field office employees, in turn, refer claimants to member agencies for food, shelter, clothing, and other social services.
- o In Bloomington, Illinois, the local field offices work with the county senior services agencies. When elderly individuals apply for home delivered meals, social workers screen them for SSI and refer those who are potentially eligible to SSA.
- o In Sioux City, Iowa, field office employees worked with a local college to set up internships which provide college credits for social work students. The students work in the community screening individuals for SSI, referring potentially eligible individuals to the field offices, and assisting them in obtaining medical and other evidence to document their applications.
- o Our Muncie, Indiana, field office arranged for "Richard's" fast food restaurants in Muncie to put SSI information on the place mats they used to line their food trays--10,000 place mats were used over a 2-week period.
- o Field and regional office employees, Congressman Jim McDermott's staff, the local Washington Department of Social Services, the DDS, and over 250 city, county, State, and private agencies established the Seattle/King County SSI Resource Consortium for the purpose of "getting the SSI message out."
- o In Fort Mitchell, Kentucky, the local SSA office arranged for the local dairy to advertise SSI on its milk cartons --in one month, more than 175,000 cartons with the SSI message were distributed.
- o The Brownsville, Texas, field office published an SSI outreach flier in English and Spanish. It appeared in the "Bargain Book," a free advertisement newspaper published periodically and delivered to every home and business in Brownsville, San Benito, and Harlingen, Texas.
- o In Fergus Falls, Minnesota, and several counties in Pennsylvania, SSA arranged for the local utility

companies to include fliers about SSI in their bills--143,000 fliers were mailed in Fergus Falls and 332,000 in Pennsylvania.

- o In Alaska, SSA field offices have made sure that various public service announcements on SSI are translated into Alaska Native American dialects.
- o In Bridgeport, Connecticut, local SSI employees go to the Spanish American Developmental Agency and take SSI applications in Spanish.

I think this gives some idea of the creative efforts being made by SSA employees. This kind of innovation is essential, because outreach is always a challenging process. One of the things that makes it so challenging is that there is no single formula for success. Instead, we must tailor our efforts to the needs of different populations in different locales.

Children with Disabilities

Now let me discuss some of the projects underway which evidence our commitment to reaching SSI-eligible children.

- o In Lexington, Kentucky, an SSA employee arranged for a message about SSI for children with disabilities to be printed on bookmarks which were distributed by public and school libraries. The libraries placed one in each book as it was checked out--300,000 bookmarks were distributed over a 3-month period.
- o Local offices have worked with over 60 different Boards of Education in 17 States including California, Texas, and Washington.

In addition, our Regional Offices have been busy identifying new ways of reaching children with disabilities. For example, Regional Offices have been working with:

- o Head Start social workers to identify potentially SSI-eligible children and family members, take applications, and obtain medical histories;
- o hospital staffs to identify eligibles, take applications, and acquire medical information that will expedite disability determinations;
- o State and local Departments of Social Services to establish procedures for screening and referring children with disabilities (as well as adults) in foster care and on the AFDC rolls to SSA field offices; and
- o local school systems to identify students with disabilities, tell their parents about the SSI program, and help them to apply for benefits.

Zebley Outreach

Mr. Chairman, I would also like to mention our progress in implementing the Zebley court decision. We are all keenly aware that the children in the Zebley class are some of the most vulnerable members of our society, and we are doing everything we can to locate them to ensure that they receive all the benefits they are entitled to.

Last July, we mailed notices to about 452,000 children affected by the Zebley decision. Since then, approximately 208,000 persons have completed forms asking for consideration as Zebley class members.

There are still approximately 138,000 persons whom SSA has been unable to reach because the notices sent to them were returned as undeliverable. SSA is working with State agencies to locate nonresponders and those whose notices were returned as undeliverable. To date, 32 States have furnished SSA with tapes to match against Social Security records in an effort to find new addresses. A second mailing, based on addresses furnished by the States, is scheduled for this spring.

SSA has worked closely, cooperatively, and effectively with a myriad of organizations, including the Philadelphia Community Legal Services, and even awarded the Mental Health Law Project a grant of \$145,000 in October 1990 for outreach to children in Maryland, North Carolina, and Texas. We certainly welcome all efforts to help us find and enroll the children who need and are entitled to benefits under the SSI program.

SSA has trained DDS examiners in every State and the District of Columbia on how to implement the court decision. Following our own evaluation of the effectiveness of that training, SSA conducted childhood conferences with more than 800 DDS examiners in 36 States.

We have held three group meetings and numerous individual meetings with social service, mental health, and advocacy groups. Together we are working to locate all potential class members.

SSA has also launched multi-media public service announcements to 5,000 radio and 750 television stations across the Nation. In addition, we have mounted an aggressive nationwide public information program to try to find eligible children in urban and rural communities.

The facts clearly show that our efforts are having an impact. Overall, childhood applications for SSI have increased approximately 250 percent since 1989. To date, we have completed about 54,000 Zebley cases, of which more than 60 percent have been allowed.

Outreach to Persons with AIDS/HIV Infection

For people disabled because of HIV infection, SSA concentrated its initial efforts on obtaining the most up-to-date information to assist development of a proposed regulation in order to speed evaluation of such disability claims. The proposed regulation would expand the medical listings in our regulations to include a specific listing for HIV infection. These expanded criteria were developed in close cooperation with medical experts in the field, including experts in pediatric HIV infection, and incorporate the latest medical knowledge about HIV disease.

Subsequently, we have launched outreach efforts to increase public awareness of the potential benefits available to people disabled because of HIV infection, including:

- o several pilot projects sponsored by AIDS advocacy groups to recruit volunteers to serve as representative payees for people with HIV infection who need help handling financial affairs; and
- o a public awareness campaign alerting people who have tested positive for HIV infection to check their Social Security earnings records to assure speedy claims processing if they need to file for disability in the future.

Some of the outreach materials include:

- o a poster featuring the Smithsonian Institution photographs of the national AIDS quilt which highlights the availability of benefits under the disability programs as well as under Medicare and Medicaid;
- o a video news release explaining how the new criteria and instructions help men, women, and children applying for disability benefits based on HIV infection;
- o a brochure in English and Spanish explaining how SSA evaluates disability claims involving HIV infection; and
- o a series of English and Spanish television and radio public service announcements explaining the disability programs and how to apply for them.

Also, still in the planning stage are:

- o an information campaign with the medical community, service providers, and advocacy groups, involving various media to reach the widest possible audience; and
- o a series of public service advertisements for newspapers and magazines.

The Homeless

This same kind of thoughtful effort is used in meeting the special needs of homeless people. In fact, we have appointed "homeless coordinators" in over 1,000 field offices. They serve as liaisons between SSA and community organizations and providers who deal with the homeless population.

As with children, there are a number of exciting and innovative efforts SSA employees are making to reach the homeless population. In addition to our activities with the VA that I described earlier, let me mention one local initiative in particular.

Local SSA employees in Baltimore have been working with city, State, and private sector service providers since early 1989 to take services to the streets to reach out to homeless individuals. More specifically, working as part of a homeless outreach team, an SSA employee, a representative of the local Health Care for the Homeless clinic, and employees from the Income Maintenance and Emergency Environmental Services of the city's Department of Social Services go wherever homeless people congregate (shelters, soup kitchens, abandoned buildings, parks, under bridges, etc.). The team completes applications and interviews on site whenever possible. In addition, the team uses a van stocked with food, used clothing, and blankets and distributes these items as needed.

Before leaving the subject of the homeless population, I want to point out that SSA does not just try to locate those who are already homeless; wherever possible, we work to prevent homelessness by contacting people who are at high risk because they are soon to be released from institutions.

To do this, we establish agreements with the institutions so that they give us advance notice of an individual's release. This gives us time to ensure that an individual who is eligible for SSI has funds for food, clothing, and shelter before leaving the institution.

The Measure of Success

SSA's outreach efforts are many and varied. But the important issue, of course, is whether these efforts have worked.

I am pleased to report that we have a strong indication that our outreach has, in fact, been successful. We continue to see a rise in the overall number of applications and awards for SSI. For example, the number of applications received during the first three months of Fiscal Year (FY) 1992 is up by 39.8 percent compared to applications made in the first three months of FY 1990, when increased outreach activity began. And, during the same period, awards went up by 42.8 percent.

Still, we recognize that SSI outreach is a task that is never completed as long as eligible people still need to be reached. For that reason, we will continue our efforts and continue to explore new ideas.

Conclusion

Mr. Chairman, in concluding my statement, I wish to restate SSA's commitment to outreach. We are proud of the strides we have made thus far. And I am particularly proud of the energy, compassion, and sheer resourcefulness of SSA employees.

Best of all, statistics show that many of our activities have been successful. But we realize this job is not finished. As long as eligible Americans are deprived of any of our programs' benefits because they did not know about them, or cannot cope with the application process, we will continue our efforts.

Chairman JACOBS. Ms. Nye, I was just kidding about the 5 minutes. Administration witnesses can consume reasonable time.

**STATEMENT OF CHRISTINE NYE, DIRECTOR, MEDICAID BUREAU,
HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. NYE. Mr. Chairman and members of the committee, I am very pleased to report to you this morning on the status of the Health Care Financing Administration's outreach efforts to qualified Medicare beneficiaries.

QMB's, as qualified Medicare beneficiaries are called, are a very important population to the Health Care Financing Administration because they represent the poorest and most vulnerable citizens served under the Medicare Program. Because of their unique status and their particular needs in this society, we have devoted extensive efforts to try to reach them and inform them about the program.

Recently, as you know, Families USA reported that 2 million older Americans continue not to receive the QMB benefit. The truth is, no one knows the exact number of people who are not receiving the benefit, but, in fact, many people are not.

Over 4 million elderly individuals have incomes below poverty, but we would need to know the income and value of each of these person's assets before we would know exactly how many people were eligible for the QMB Program.

We do know, however, that the Federal Government and State governments are jointly paying Medicare premiums, coinsurance, deductibles, and buying into Medicare for nearly 4 million individuals enrolled in State Medicaid programs. These payments amount to about \$5 billion annually.

While our data do not break out the poverty-level individuals from recipients with incomes above poverty, they do indicate considerable QMB program participation in the buy-in program that exists.

We recognize that there are yet other persons potentially eligible for the benefit, and we have been making every effort to identify and notify these beneficiaries of the availability of the benefit.

Shortly after enactment of the QMB provisions in the Medicare Catastrophic Act of 1988, HCFA took steps to implement the benefit. For example, in October 1988 we sent a letter to all the Governors and all the State Medicaid directors informing them about the various provisions of the benefit and what Federal and State responsibilities were relative to it.

Second, we issued instructions to the States about how the program was to work, and in the summer of 1989 we mailed OMB notices to over 14 million potentially eligible Medicare beneficiaries.

These initial efforts told us that it is very difficult to identify and enroll people in these programs.

Unexpectedly, of the 14 million elderly people who received this notice, only a small percentage, unfortunately, qualified for the program. Many met the income requirements, but when we looked at assets, they were not eligible for the program.

In August 1991, we reevaluated our efforts and formed an outreach workgroup with people inside and outside the Department to explore various ways to reach this population. As a result, there has been extensive activity in terms of putting articles in the daily and weekly newspapers and in popular magazines which elderly people read. We have distributed a highlight factsheet about the QMB benefit and what it takes to be eligible for it, and it has been displayed in over 7,000 supermarkets nationwide.

We also have contracted for the development of an easy screening tool which people or outreach workers or advocacy workers could use to screen individuals to determine whether they are, in fact, eligible. This could be used at churches, senior centers, nutrition sites, et cetera.

We have also done public service announcements for 325 TV stations and 4,000 radio stations nationwide. Last September, we established a toll-free hotline with specific information about the QMB benefit, which I am very pleased to say has received in the last month over 4,100 requests for information about the QMB benefit.

Also at the end of the year, SSA distributed a stuffer with its SSA Social Security check, giving information about the QMB Program. AARP published an article in its magazine about the QMB benefit. We have included information in the Medicare handbook about the QMB benefit, plus this year when we sent out the notice about the part B buy-in program, we also notified people about the availability of the QMB benefit.

These are among many of the activities that we have been involved in, which are also included in the more extensive testimony that you have received.

Beyond notifying eligibles of program benefits, it is important to note that if someone is aware of the program, they must actually apply at the State Medicaid agency or public assistance/welfare or human service office for this benefit. This point has been confused by some people.

To establish an alternative application process at the Social Security office, as was mentioned earlier, would cost increased Federal funds which are not now available.

One of the things that we looked as part of our outreach work in the last year was the most cost-effective way to conduct outreach. Because of our experience with the virtual ineffectiveness of the mass mailing which also results in lots of calls to already overburdened welfare offices with little success, we concluded that targeted outreach activities, trying to target to where actual poor seniors live and congregate, is the most effective way to reach them.

We have been working hard to target public service announcements in areas with the largest concentration of eligibles. Factsheets have been distributed at senior centers, nutrition sites, and to outreach workers. We have also written articles for use by advocates and Members of Congress.

In short, we have made considerable effort to set up and coordinate activities to publicize the QMB benefit. These activities could hardly be seen as operating a secret benefit.

For the long term, we are developing software tools for people to use at senior centers to screen beneficiaries. We think that will be very useful.

We have also awarded a grant to Project HOPE recently to identify how we can more effectively reach these people, and we are looking forward to the results of the study.

And we are also in the process of awarding 10 million dollars' worth of grants to State-level counseling programs, one aspect of which is to identify and work with elderly people to get them into this program, and that should begin this fall.

These ongoing activities clearly demonstrate our interest and an ongoing commitment, to reach and identify these elderly people and get them to participate in the program.

Thank you, and I will be happy to answer any of your questions.
[The prepared statement follows:]

TESTIMONY OF CHRISTINE NYE, DIRECTOR, MEDICAID BUREAU
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH & HUMAN SERVICES

Chairmen and Members of the Subcommittees, I am pleased to be here today to report to you on the current status of the Health Care Financing Administration's outreach activities for qualified Medicare beneficiaries (QMBs).

Qualified Medicare beneficiaries are an important population to HCFA because they represent the most socio-economically vulnerable citizens served by the Medicare program. Because of the unique status of these individuals, our efforts to contact them have been far-reaching.

Secretary Sullivan is personally concerned with the notification and enrollment of QMBs and is utilizing fully the resources of the Department to promote awareness of the benefit. The QMB benefit entitles certain low-income Medicare beneficiaries to state Medicaid assistance in paying their Medicare premiums, deductibles and coinsurance.

Recently, a Families USA document reported that 2 million older Americans are not receiving the QMB benefit. The truth is, however, that no one knows the precise universe of this category of beneficiary.

An estimated 4.2 million elderly individuals have incomes below poverty. But, we would need to know the income and value of every elderly and disabled person's resources nationwide to determine exactly who is eligible for the program.

What we do know is that the Federal government and states are paying Medicare premiums, coinsurance and deductibles for nearly 4 million individuals enrolled in state Medicaid programs. While this figure cannot break out poverty-level individuals from recipients with incomes above poverty who are eligible for both Medicare and Medicaid, it does indicate considerable QMB program participation. States and the Federal government will spend nearly \$5 billion in FY 1992 for Medicare Part B physician premiums, Part A hospital premiums, coinsurance and deductibles.

Nonetheless, HCFA recognizes there are yet other individuals potentially eligible for QMB program benefits. In this light, the Department and HCFA have made, and continue to make, every effort to identify and notify beneficiaries about this important program.

BACKGROUND/INITIATIVES

States were first required to "buy-in" to Medicare for low-income seniors and persons with disabilities on January 1, 1989, through provisions enacted in the Medicare Catastrophic Coverage Act of 1988. States were required to phase-in this assistance for Medicare beneficiaries with incomes up to 100 percent of the federal poverty level (FPL) by January 1, 1992. Subsequent legislation accelerated the phase-in by one year (1991) and added buy-in requirements for beneficiaries with incomes up to 110

percent of the FPL by 1993 and 120 percent of the FPL by 1995 for part B premiums only.

To be eligible in 1992, applicants must have incomes below \$6,810 and assets of less than \$4,000 if single, and incomes below \$9,190 and assets of less than \$6,000 if married.

Since enactment of these laws, HCFA has moved to implement the new buy-in program. In October 1988, HCFA sent a letter to all State Governors and Directors of State Medicaid programs alerting them to the new QMB benefit and outlining Federal and State responsibilities for implementation. A State Medicaid Manual issuance in December 1988 contained comprehensive policy and systems instructions for the States to enroll beneficiaries and pay their portion of Medicare cost-sharing.

To help States notify potentially eligible beneficiaries, HCFA provided the States with magnetic tape files of the names and addresses of Social Security beneficiaries whose incomes would likely qualify them for the QMB program.

Some States conducted their own outreach to provide information and notify potentially qualified beneficiaries of the QMB benefit. HCFA made a special mailing in the summer of 1989 of a one-page notice to approximately 14 million Medicare beneficiaries identified by the Social Security Administration as

potentially eligible for the QMB benefit. The notices included State-specific locations and telephone numbers for further inquiry.

In preparation for the mailing, the Social Security Administration sent an information package to its 1,300 district offices describing the benefit with a series of questions and answers district office workers could use in responding to beneficiary inquiries.

These efforts taught us that Qualified Medicare Beneficiaries are difficult to identify. Of the large number of beneficiaries who responded to the direct mailing, only a small percentage actually qualified for the program. Many met the income requirement but had too many assets to qualify.

A QMB inquiry unit established in HCFA's central office responded to over 15,000 written and telephone inquiries in a period of just six months; but, again, many inquirers exceeded asset requirements for program participation.

In August of 1991, the HCFA Administrator formed an Outreach Workgroup with other HHS agencies and public interest groups to explore methods of increasing public awareness of the QMB program.

As a result of workgroup activities:

- o News and feature articles about the benefit prepared by HCFA, SSA, Administration on Aging, and the American Association of Retired Persons were published in popular magazines, beneficiary organization magazines, and daily and weekly newspapers. Tens of millions of people were reached by this effort.
- o HCFA distributed more than 2 million Highlights leaflets with QMB information and will issue 1 million more this year to be distributed in over 7,000 supermarket displays across the country.
- o A "screening" short form was developed to help outreach workers identify and assist those likely to qualify.
- o Broadcast media releases were produced with videotape public service announcements. These releases have been distributed to 325 TV stations and 4,000 radio stations nationwide.
- o A toll free hotline was established that advises beneficiaries which office in their state to contact for further information and referral for QMB program sign up and benefits. The American Public Welfare

Association worked with HCFA in preparing a more detailed State/county contact list to be used by hotline operators to refer callers to appropriate offices.

- o The Social Security Administration distributed a check stuffer to all its beneficiaries with an explanation of the benefit and instructions on how to apply.
- o The American Association of Retired Persons (AARP) printed articles on the QMB benefit in Modern Maturity magazine, which reaches 33 million members, and AARP volunteers have been trained to identify and assist potential eligibles with applications.

HCFA also notifies new beneficiaries of the QMB benefit by providing information in the Medicare Handbook. This handbook is mailed to all new Medicare beneficiaries and has included QMB information since 1989 when it was sent to all Medicare enrollees.

Other activities include the implementation of public information campaigns by HCFA and the Social Security Administration (SSA) to increase program awareness. HCFA is exploring new ways to identify potential eligibles for follow-up by the States. The Administration on Aging (AoA) is also providing information on

the QMB program to State and Area Agencies on Aging for distribution to senior centers and service providers.

As part of a national program begun last year, HCFA created the Partnerships in Health Insurance Counseling Program (PHIC), a Federal/State partnership which uses local volunteers to provide community-based counseling for senior citizens.

HCFA recently awarded a research grant to Project HOPE to produce more precise national estimates on the size and characteristics of the QMB population, to determine major information sources for both groups, and to identify barriers to program participation.

ENROLLMENT ISSUES/COSTS

Beyond notifying eligibles of program benefits, the QMB enrollment process is an issue of some concern. Beneficiaries must apply at their State Medicaid or public assistance office. The QMB program is a Medicaid-mandated benefit; not a Social Security mandated benefit. This point has been confused by advocates who assume Social Security offices can readily determine QMB eligibility.

To establish an alternative application process at Social Security offices would require considerable expenditures of Federal funds. We must keep in mind that funding is not available to support the additional training of Social Security

personnel when Medicaid agencies are already staffed to provide this service.

We must also consider the cost-effectiveness of different outreach methods. In the current budgetary environment, dollars must be spent wisely. Mass promotions and broad public information campaigns have been tried before, sometimes at great expense and with poor results. For example, the direct mailing to 14 million potential beneficiaries in 1989 cost over \$2.0 million but resulted in few additional enrollees. Even if funds were readily available, which they are not, we have no reason to believe another mailing would be more effective than the one in 1989.

Early on, the Outreach Workgroup concluded that many promotional activities generated a large number of applicants but few were eligible for program benefits. Moreover, State resources were too limited to cope with the resultant flood of inquiries. Additional use of mass promotion techniques would further overwhelm already overburdened local welfare offices. What is needed is clear, carefully targeted information.

While some argue that the cost of outreach activities should not be a factor, current pressure on both State and Federal budgets demands that we pursue methods with the greatest promise of generating results without excessive costs.

As it stands, HCFA has been working with Federal agencies and public interest groups to utilize their resources and distribute QMB benefit materials throughout the aging network; we have targeted public service announcements in areas with the largest concentration of potential eligibles; developed fact sheets for distribution to senior centers; and, written articles for senior publications and for use by advocates and members of Congress.

Clearly, the Department of Health and Human Services is actively engaged in making low-income Medicare beneficiaries aware of the QMB program and improving their access to it.

ACCOMPLISHMENTS/GOALS

In short, HCFA has solidly established and coordinated activities to publicize the availability of the QMB benefit. Considerable progress has been made and States are upgrading reporting systems to ensure that enrollees are accurately reflected in their records. These efforts can hardly be regarded as "secretive".

For the long term, the United Seniors Health Cooperative has developed a proposal to produce a worksheet and software tool to be used to facilitate the screening of the QMB population, and to disseminate these tools to community-based organizations.

No less noteworthy is HCFA's \$10 million health insurance information, counseling and assistance (ICA) grant program for

state agencies. This program includes a QMB outreach component which, in many instances, will be implemented through the Partnerships in Health Insurance Counseling Program.

These Department, agency and interest group activities demonstrate that the Federal government is not neglecting the implementation of this important program. Our efforts have consistently included the participation of agencies and advocates closest to the people involved. We have maximized available resources to date and will continue to pursue the effective administration of the QMB benefit in the future.

Thank you for inviting us here today to report to you on the progress of the QMB benefit program. I'll be happy to answer any of your questions at this time.

Chairman JACOBS. Thank you, Ms. Nye.

Mr. Bunning.

Mr. BUNNING. Thank you, Mr. Chairman.

Mr. Enoff, I understand that pursuant to the 1983 amendments, SSA sent out about 7.6 million notices to Social Security beneficiaries, who it appeared might be eligible for SSI. It is my understanding that less than 1 percent of them filed an application and were approved for benefits.

I wondered if you know if that is true or not true?

Mr. ENOFF. I believe those numbers are correct, Mr. Bunning. There is a low response from those general mailings that are not targeted, as Ms. Nye indicated.

Mr. BUNNING. Some of the witnesses that are going to testify and have testified suggest that SSA make a personal contact with those who failed to respond to the notices, and many witnesses propose that SSA take the QMB application.

Do you think that the SSA could handle that kind of a workload? Do you have the capability of doing it?

Mr. ENOFF. Currently we do not have the staffing or the resources to handle QMB applications. We are at capacity now with the disability program. It would require a substantial amount of additional staff and resources for us to do the QMB application process.

Mr. BUNNING. One question for Ms. Nye.

Ms. NYE. Yes, sir.

Mr. BUNNING. I understand that neither CBO or OMB estimated the cost of the QMB at 100 percent.

Can you provide the Administration's estimate and the background for it?

Ms. NYE. I cannot give you that estimate right now, but I could provide it to you for the record.

Mr. BUNNING. I wish you would do that. Thank you.

Ms. NYE. I will do that.

[The information of Ms. Nye follows:]

We are currently spending approximately \$5 billion annually (in combined Federal and State funds) on QMBs and individuals dually eligible for Medicare and Medicaid. It is difficult, at this point, to separate the QMBs from the dual eligibles. Studies, such as by Families USA, indicate that we are currently reaching about half of all QMBs. If we assume a similar percentage for the dual eligibles, then the total costs would double to approximately \$10 billion annually.

Additionally, it should be noted that such an extensive outreach effort would probably increase the number of enrollees and the costs of other programs, such as SSI.

Chairman JACOBS. Mr. Downey.

Mr. DOWNEY. Thank you.

Lou, there have been a number of studies of homeless persons in cities, and they have found that few of these individuals receive SSI benefits.

What is your estimate of the number of homeless persons currently receiving SSI or SSDI?

Mr. ENOFF. I do not have an estimate, Mr. Downey. I would be glad to try to come up with one.

[The following was subsequently received:]

Because homelessness is not a factor that has any effect on establishing or maintaining eligibility for SSI, we do not record in our computer system any indicator or

data about a person's being homeless. A person who is homeless may have checks sent to an address in care of a relative or friend or to a provider of services—e.g., a shelter—or to a post office box or general delivery. If there is no other alternative, SSA field offices will receive and disburse checks until a better arrangement can be made. Consequently, we have no data on the number of people on the SSI rolls who are homeless at any given time.

There also would be great difficulty in attempting to determine among homeless people how many might be eligible for SSI or Social Security benefits. Given the difficulties in estimating the number of persons who are homeless, we prefer to acknowledge that we have a lot of work to do to serve persons who are homeless who are eligible for benefits from our programs. That is why we are using our outreach demonstration funds to test models of outreach to this population as well as others.

Mr. ENOFF. As I say, we have targeted homeless populations in various cities and have had some success, but we believe that is an area that we need to continue to work on. We will be looking at additional grants to try innovative methods of reaching the homeless population.

Mr. DOWNEY. Let me ask you a question about that, because I know in the early 1980's SSA operated a special outreach program in New York City shelters.

Do you know if that is still operating?

Mr. ENOFF. We do have a project in New York City, and I would be glad to give you an update on its status. As I indicated, our efforts include an overall effort that we use with national organizations, and then locally there are many innovative activities, as well as the demonstration projects.

We get reports from our regional and local offices two or three times a year that tell us what they are doing, and then we try to replicate those activities that appear to have some potential. So I would be glad to share with you, if your staff does not already have the report dealing specifically with New York.

[The following was subsequently received:]

In New York City (NYC), SSA and the Disability Determination Service (DDS) are committed to continuing a productive outreach program to help homeless individuals obtain disability benefits for which they are eligible. In this collaborative effort, the NYC Human Resources Administration (HRA) schedules the dates and locations for the on-site taking of applications, and the shelters submit the names and Social Security numbers of potential applicants to the SSA field offices in advance. SSA field office representatives go to the shelters to take applications, and they are accompanied by DDS analysts who assist in the development of the necessary medical evidence. HRA psychiatrists examine the applicants, and social workers at the shelters provide background summaries, which are helpful in determining whether individuals meet SSA's definition of disability. If the disability analysts determine that additional medical examinations are required, a city van takes the applicants to the examinations, usually on the same day. SSA and the DDS then expedite the processing of these applications.

Mr. DOWNEY. Yes, I would be interested in that.

And did I hear you correctly in saying that something like the New York program is something that you are replicating or will replicate?

Mr. ENOFF. It depends. What we have found is that different outreach efforts work in different localities. We need to have the right combination of advocates or State or local agencies working with us.

One of the principles of our outreach is to establish permanent linkages to organizations in the community, and so we try to be adaptable to what is in place in that community and use those existing persons who know the population better than we do.

Mr. DOWNEY. Some of the advocates, from whom we will hear later, assert that homeless persons suffering from mental illness should be presumed eligible for SSI or should be given an expedited disability determination process.

Does this make sense to you?

Mr. ENOFF. Presuming disability is a very difficult process. We do have presumptive disability for those medically determinable impairments that are visible. But presuming disability for individuals with mental impairments would be a most difficult leap for our workers in the local office, because they are not trained or equipped to make disability determinations with regard to mental impairments. As you know, making presumptive disability determinations would involve both some difficulty and some potential risk.

Mr. DOWNEY. Do you have any procedures in place for helping mentally handicapped homeless persons to work their way through the process?

Mr. ENOFF. Absolutely.

Mr. DOWNEY. Could you describe these procedures?

Mr. ENOFF. Absolutely. I know, for instance, in New York, since you had mentioned New York earlier, the Disability Determination Service in New York has a program that assists persons in getting the medical examinations they may need to prove their disability. One of the things they do is to help the individual get transportation to and from the medical source.

So we do have those kinds of programs. I happen to know about the New York DDS Program. But we have different programs in different parts of the country.

Mr. DOWNEY. Can you describe the extent to which these programs are operating around the country? Do you have one or two? How many people do you have?

Mr. ENOFF. Certainly, several. But again, I can give you a listing of them. They vary from place to place. Not all of the disability determination services provide that kind of service that I mentioned in New York. But it is done more than in New York.

[The following was subsequently received:]

SSA is testing several models for helping mentally ill homeless individuals through the disability process. As an example, SSA has begun a collaborative initiative with the Department of Veterans Affairs' (VA) successful Homeless and Chronically Mentally Ill Program. In New York City and Dallas, SSA field office personnel and DDS analysts are stationed at VA homeless outreach sites to work as a team with VA personnel to provide a wide range of integrated services to veterans who are homeless. The services include taking applications, assisting in documenting claims, with particular emphasis on the medical evidence, processing applications expeditiously, arranging for representative payees when necessary, and providing job rehabilitation and housing. We plan to expand this project to Los Angeles and test another model that uses a new position that combines the duties of a claims representative and a DDS examiner. This is a demonstration project, and SSA will evaluate the results and expand this integrated services model across the country if it proves successful.

SSA also has a number of initiatives on the local level that are designed to assist the homeless and mentally ill. Some examples include: stationing DDS claims examiners at the SSA field office in Linda Vista, California, to expedite disability claims; having a disability examiner stationed at an SSA field office in Detroit part-time and accompanying SSA staff to homeless shelters to assist in taking disability claims; and having SSA and DDS staff visit shelters in Massachusetts to take claims and to arrange for consultative examinations.

Mr. DOWNEY. You agree with the proposition that these people need substantial help to get through the bureaucratic maze, as a proposition, do you not?

Mr. ENOFF. They do, and we try to provide that or acquire that from other sources.

Mr. DOWNEY. In the last 3 years, the Congress has appropriated \$15 million for outreach demonstration projects. Can you provide detailed information to the committee on the projects you have funded? How much of the \$15 million have you encumbered for projects? How do you plan to spend the entire \$15 million?

Mr. ENOFF. Yes. I think it is three, six, and six in 3 different years. Thirty-three projects have been funded thus far and 20 will be finished by the end of this month.

We have a contract in place to evaluate those projects, and the first 12 will be evaluated by October. We expect to let another 40 grants this year. We have received several hundred proposals as a result of our announcement last September, and we would expect to let those other 40 grants within the next 5 or 6 months.

Mr. DOWNEY. Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Downey.

Ms. Nye, you mentioned the cost of the so-called one-stop lot approach at the Social Security offices, which I presume would be borne by your agency and the insufficient funds for it. But you did not mention what you estimate the cost to be annually.

Have you a figure?

Mr. ENOFF. It depends on how many QMB eligibles you estimate. If you take the 2 million that was cited in the Families USA report, we estimate that it would cost about 6,000 work-years and over \$250 million for a full-scale effort to take and process QMB applications.

Chairman JACOBS. Are you familiar with the Congressional Budget Office estimate?

Mr. ENOFF. No, I am sorry. I am not.

Chairman JACOBS. Well, they come in at \$24 million a year—\$120 million over 5 years. Now I do not know the details of that study, but I understand that we do have the study. And I think rather than your making something available to us in this instance, we might make that available—

Mr. ENOFF. Sure. I would be pleased to comment on it.

[The following was subsequently received:]

The Congressional Budget Office (CBO) provided the following detail behind its estimates for this proposal: Cases per year, 300,000¹; cost to process each case, \$125; 5-year cost based on midyear implementation, \$170 million.

We agree with the \$125 cost per case assumption used in the CBO estimate. The difference between the CBO estimate and the SSA estimate of \$250 million is that our estimate is based on the 2 million potential eligible figure in the Families USA report, whereas CBO assumes a volume of approximately 1,350,000 cases (150,000 in FY 1993 and 300,000 per year in FY 1994–1997).

It is important to note that SSA's administrative appropriation legally cannot be used for Medicaid work. Funds for this activity would need to be appropriated to HCFA. If necessary, for SSA to do some work, HCFA would pay for it through a reimbursable agreement.

¹ 150,000 in fiscal year 1993 based on midyear implementation.

Chairman JACOBS. I frankly find more logic in the notion of administering it in one place, because I understand there are some scare stories about the approval having been obtained or the eligibility having been determined at the welfare office and then a delay, so that people are billed from the Medicare program or from a hospital or something like that, and I do not know exactly what the wisest way to coordinate it is, but offhand you would say if the left or the right hand were doing it all, the coordination would be greater.

Is there any sense in that to you?

Mr. ENOFF. Well, in regard to doing the work, we would assume that we could phase it in or something, if it were to be done.

But one thing that is often assumed is that because most of these persons have some business with Social Security, they would be at the Social Security office. But most persons who deal with us for retirement benefits—70 percent of people who apply for retirement benefits—do that before age 65, before they are eligible for Medicare, and we do not deal with them, except to send them an eligibility notice about Medicare, when they turn 65. That notice does include information about QMB.

But they are not necessarily interacting in the Social Security office at that time, so it's not a case of one-stop service.

Chairman JACOBS. I appreciate that. What I was getting at is the coordination of eligibility and implementation, apart from where anybody is, apart from how you notify people of their rights. As they used to say in the Marine Corps, there is always 10 percent that does not get the word. But maybe we were substandard—I am not sure—but I think it might apply to society and human beings generally.

A thought just occurred to me: in your outreach programs, there are certain radio stations around the country that specialize in old-time music. Do you appeal to them specifically?

Ms. NYE. Those are among the situations we send public service announcements to.

Chairman JACOBS. What are the results? Are the broadcasters helping? Are they pushing that at all?

Ms. NYE. It really varies. I think, particularly when there is a lot of press about an issue, that most of the radio stations are very helpful, particularly those radio stations that serve more of an elderly population.

So those that focus more on that population would pick up more on the public service announcements.

Chairman JACOBS. Well, it seems to me that a station manager is more likely to read the morning paper than maybe some of the elderly people who are disabled. And you might have a two-stage notification there, where you persuade the station managers of the pathos of the thing and the patriotic duty and so on and so forth, but motivate the station manager, who in turn does something that is more likely to reach a person.

I mean, I hate to say it, but when notices are enclosed in mass mailings, they are notoriously trashed in fairly rapid order. So I think maybe that one-two punch might be an idea.

But thank you very much for your contributions to the record. We appreciate it.

Our next panel consists of the organizations, Families USA, Ronald Pollack; the National Council of Senior Citizens, Daniel Schulder; the American Association of Retired Persons, Lena Archuleta; and the National Senior Citizens Law Center, Patricia Nemore.

If you would proceed in the order in which you are listed and out of kindness to the succeeding witnesses, stay within the 5-minute limit, the red light will tell you when to put on the brake.

I think Mr. Pollack is first.

**STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR,
FAMILIES USA**

Mr. POLLACK. The red light is not on yet, is it?

Chairman JACOBS. No, you have a green light. Go.

Mr. POLLACK. Thank you. Thank you, Mr. Chairman.

I would like to put into perspective the importance of this QMB benefit that we have been talking about this morning. This legislation was enacted, I think, because Congress took cognizance of the fact that the cost-sharing features of the Medicare Program have grown enormously, and for this very targeted population, it constitutes a very substantial portion of their entire income. Let me give you some examples.

In 1980, the part A deductible, which is a deductible every time a senior citizen or disabled person is hospitalized, was \$180. Today in 1992, it is \$652. It has increased by more than 3½ times over the past 12 years.

The part B premium, which is a required payment if you want to receive outpatient services and physician services, in 1980 was \$104.40 on an annual basis. Today it is \$381.60. That, too, has increased by more than 3½ times.

The part B deductible, which you pay annually if you want physician services, increased from \$60 to \$100.

And finally the part B copayments after you pay the premium, after you pay the deductible, you pay a 20 percent copayment for all additional services. The average part B copayments for seniors in 1980 was \$138. Today it is \$468. Here, too, it has almost increased by 3½ times.

Now let me just aggregate those expenses for you, if I may, because I think it gives you a pretty good sense of how important this QMB benefit is for this targeted population.

First of all, we are talking about a person living alone with an income of approximately \$7,000 a year or less, assets of less than \$4,000. We are talking about a couple with income of less than \$9,400 with assets of less than \$6,000.

Now if you take a senior citizen who is hospitalized once in the course of the year, the minimum that they would be paying out of pocket would be over \$1,600. They would be paying \$652 for the hospital deductible. They would be paying the premium for part B coverage. They would be paying the deductible, and they would probably be paying at least the average copayment for part B.

So in the aggregate, they would be paying over \$1,600 out of their income of less than \$7,000.

Now to also put that into perspective, let us understand that there are a wide variety of services that Medicare does not cover that they also have to pay for. Medicare does not cover prescription drugs. It does not cover long-term care, preventive care, eyeglasses, hearing aids, dental care, prosthetic care.

So for a senior citizen who has an income of less than \$7,000, it means that they are paying approximately a quarter of their income on premiums, deductibles, and coinsurance, let alone other expenses.

That is why this QMB benefit is tremendously important. The Families USA reports—one report which was issued in June, the other report which we issued a few weeks ago to do an update on the number of people eligible who are not participating—today there are over 2 million people eligible for this benefit, desperately poor, who are not receiving it.

In your State, Congressman Jacobs, there are over 42,000 very low-income senior citizens eligible for this benefit; 65 percent of the people eligible for the benefit in your State are not receiving it.

Mr. Bunning, in your State, there is a better participation rate. Almost 30,000 people in the State of Kentucky are eligible for this benefit and are not receiving it—33 percent of the people in Kentucky eligible for this benefit are not receiving it.

I understand that I have to close my testimony. I would just close by saying that the bill offered by Congressman Moody, I think, offers a very thoughtful approach to solving this problem, and we support that bill.

[The prepared statement follows:]

Testimony by

Ronald F. Pollack
Executive Director

Families USA

before

HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEES ON HEALTH, HUMAN RESOURCES,
AND SOCIAL SECURITY

U.S. HOUSE OF REPRESENTATIVES
Washington, DC

March 26, 1992

Mr. Chairmen, I am Ron Pollack, Executive Director of Families USA. Thank you for the opportunity to discuss with you today the continuing abysmal failure of the Administration and the state governments to provide Medicare buy-in benefits, also known as qualified Medicare beneficiary (QMB) benefits, to millions of poor seniors.

Families USA strongly supported creation and expansion for the buy-in program from its inception and has worked closely with Congress so that millions of low income seniors and persons with disabilities can benefit from this program.

In 1988, Congress created the buy-in program when it required the Medicaid program to pay the Medicare cost-sharing requirements, including premiums and deductibles, for very low-income Medicare beneficiaries. Congress, for its part, created a benefit that held great promise for 4.2 million vulnerable Americans in need of decent health care.

The Administration, for its part, has ignored Congress' intent and has kept the QMB promise a close secret since its creation. In June of 1991, Families USA Foundation published its findings that approximately 2.3 million Medicare beneficiaries eligible for buy-in protection still were not receiving the benefit. It's outrageous to find that, 9 months and many Administration promises later, virtually nothing has changed.

A follow up report by Families USA Foundation issued this month, shows only an estimated 4 percent increase in the number of Medicare beneficiaries receiving the buy-in. We believe the Administration should be working aggressively to identify all individuals eligible for this important program toward the goal of full participation. The number of eligible receiving the benefit since our 1991 report was released has increased by only an estimated 152,000, undoubtedly as a result of the unprecedented publicity this issue won. This is just not good enough.

Since publication of our reports, Families USA Foundation has been deluged with phone calls from poor Medicare beneficiaries and their families only hearing of the QMB program for the first time. We have sent out over 20,000 fact sheets about the QMB benefit and how to get it. We continue to get calls on a daily basis that indicate the barriers poor seniors are facing to getting these benefits.

Last week a man called on behalf of his father in Florida. Florida Medicaid officials were telling his father that because of recent state cutbacks in Medicaid eligibility his father was no longer eligible for the buy-in.

Eligibility workers in Baltimore did not have correct information about the income eligibility standards and incorrectly told three separate applicants last Friday they were ineligible for the buy-in.

In contrast, Washington State, which has the highest percentage of eligible QMBs in the country, began training Medicaid officials around the state about the QMB program in early January 1989.

Families USA has suggested and tried to urge the

Administration to adopt a number of meaningful ways, outlined later in this testimony, to increase participation in the QMB program. A number of Members of Congress, led in the House by Congressman Moody and Kostmayer have introduced strong legislation that would eliminate the current barriers to the benefit faced by seniors and the disabled.

If the last nine months suggest nothing else, it's that nothing short of Congressional action will finally address this on-going problem.

BACKGROUND

Medicare beneficiary premiums and deductibles have escalated very rapidly over the past decade. Since 1980, the Part A deductible for each hospitalization increased 262 percent, from \$180 to \$652. The Part B premium increased 266 percent, from \$104.40 to \$381.60 annually. The Part B deductible increased 67 percent, from \$60 to \$100 annually.

Out-of-pocket costs in 1992, for Medicare beneficiaries with one hospitalization, are at least \$1,601.60 -- assuming at least average Part B copayments and not including the costs of the services uncovered by Medicare, such as prescription drugs, long term care and numerous others. These costs constitute almost one-fourth of the annual incomes of individuals with incomes below poverty -- their entire income for three months.

CONGRESSIONAL ACTION

Congress has taken important steps in recent years to prevent the extreme financial hardships that such cost-sharing requirements create for low-income beneficiaries. In the Medicare Catastrophic Coverage Act of 1988, Congress created the QMB program when it required the Medicaid program, beginning in 1989, to "buy-in" to Medicare low-income seniors and persons with disabilities eligible for Medicare.

As of January 1, 1989, Congress required buy-in coverage for Medicare beneficiaries with incomes at or below 85 percent of the federal poverty guideline and resources of up to \$4,000 for an individual and \$6,000 for a couple (excluding the home, car, personal effects, life insurance and burial spaces). Under the law enacted in 1988, the income eligibility standard for the buy-in increased to 90 percent of the poverty guideline in 1990 and was scheduled to increase to 95 percent of the poverty guideline in 1991 and 100 percent in 1992.

As the legislation was being debated in June 1988, a number of Members of Congress emphasized the importance of the new financial assistance the legislation provided to poor Medicare beneficiaries.

In Fall 1990 when Congress increased Medicare cost-sharing amounts as part of its deficit-reduction package, Congress also acted to protect low-income beneficiaries from these increases. Congress accelerated the buy-in requirement for all poor Medicare beneficiaries with limited resources to 1991, rather than 1992, and added buy-in requirements for Medicare beneficiaries with incomes up to 110 percent of the poverty guideline in 1993 and 120 percent of the poverty guideline in 1995. Medicare beneficiaries with incomes between 100 and 120 percent of the poverty guideline will be eligible for Medicaid payment of Medicare premiums, but not for Medicaid payment of other Medicare cost-sharing.

Congress also provided Medicare buy-in benefits to the relatively small number of seniors and persons with disabilities who did not work long enough to qualify for hospital coverage under Part A of Medicare. For individuals without a sufficient work history, Medicare hospital coverage is only available if they pay a monthly premium of \$192 -- an amount that is unaffordable for the poor. The law requires Medicaid to buy low-income seniors and persons with disabilities into Medicare Part A. This is an important benefit -- even for those who previously qualified for Medicaid coverage. Medicare hospital benefits are sometimes more comprehensive than Medicaid hospital benefits because some states impose strict limits on the number

of hospital days covered under Medicaid.* In addition, the Medicare payment rate is often more generous than Medicaid hospital payment rates, and Medicare therefore offers better access to hospitals.

KEEPING THE BUY-IN BENEFITS A SECRET

Despite Congress's clear intent that poor Medicare beneficiaries receive immediate financial assistance, the Medicare buy-in has remained a secret benefit. The Administration and the state governments have not taken the steps necessary to make the benefit a reality for the majority of poor beneficiaries.

Impoverished Medicare beneficiaries, who previously were ineligible for or did not receive Medicaid, have no way of knowing about the buy-in benefit. They have no way of knowing that their Social Security checks are wrongfully being deducted by \$31.80 per month (or \$63.60 for couples). They have no way of knowing that they do not have to pay the \$652 deductible for each hospitalization. And they have no way of knowing that they do not have to pay the \$100 physician care deductible, or the various other copayments they may be making. And if they do learn about the benefit, they also learn that applying to get the benefit is often no simple matter.

In the Spring of 1989, Families USA Foundation issued a report that was critical of the Administration's and the state governments' implementation of the buy-in legislation. (At the time that report was issued, the buy-in eligibility requirement was 85 percent of poverty -- not 100 percent of poverty as required today.) In response to that report, the Administration, in July 1989, sent a notice informing half of all Social Security beneficiaries that they may be eligible for buy-in assistance. Since that time, the income eligibility for the benefit has increased significantly, but the Administration refused to send any additional notices and failed to initiate any other outreach to low-income eligible persons until our June 1991 report.

An additional and important issue involves coverage of the Medicare Part A premium. The Health Care Financing Administration can identify approximately 337,000 seniors and persons with disabilities nationwide who are receiving Medicaid but are not getting the Medicare hospital coverage to which they are entitled.

GETTING THE BENEFIT TO POOR SENIORS

The application process for the buy-in benefit is not simple. Even those low income beneficiaries who now know about the buy-in must overcome significant obstacles before they actually receive the financial protection to which they are entitled. In many states, individuals must apply in person at a local department of social services. For an older person in poor health or a younger person with disabilities, this can mean an arduous trip on public transportation to an unsafe neighborhood, and then a long wait in a physically uncomfortable setting. Even if the state allows applications to be mailed, the application is difficult to read, understand and complete without professional assistance. Finally, the applicant must be able to produce the documentation required to substantiate the information on the application.

Congress has been struggling with the Administration, since the program began, to turn the QMB program into a reality. Since 1988, no fewer than 8 letters have been sent to the Secretary of Health and Human Services urging immediate action to inform Medicare beneficiaries of the program and to increase outreach activities. A total of 21 Senators and 125 Representatives have voiced their strong concern about these matters, many of them more than once.

There are a number of steps the Administration and the state

*In the following states Medicaid hospitalization benefits are more limited than Medicare hospitalization benefits according to the latest state plan information in Commerce Clearing House's, Medicare and Medicaid Guide: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia and West Virginia.

governments can and must take to ensure that low-income Medicare beneficiaries receive the buy-in benefits to which they are entitled. We were disheartened that the Health Care Financing Administration responded to our recommendations by expressing a clear intention to rely primarily on private sector volunteers for outreach. Only the federal government has the capability of launching an outreach campaign that will achieve the results Congress expected. Private efforts may supplement federal efforts to make potentially eligible individuals aware of the benefit, but only the federal government can assume responsibility for making sure that it is easy for such individuals to actually get the benefit.

Steps that the Administration must take to reach poor Medicare beneficiaries eligible for buy-in assistance include:

■ **Taking applications at Social Security offices**

Many Members have proposed that applications for the buy-in be taken at Social Security offices and for Social Security personnel to be trained to assist seniors with completing these applications. This would make it possible for seniors to apply for the buy-in at the same time as they apply for Social Security and Medicare. Furthermore, Social Security offices are often in locations that are safer and easier to reach by public transportation than local Medicaid offices.

To date, the two most relevant agencies in the Department of Health and Human Services—the Health Care Financing Administration (HCFA) and the Social Security Administration (SSA)—have not acted on these proposals and have opposed legislation mandating such a change. Taking applications at Social Security offices is an example of a strategy that the President is proposing to achieve high participation in his health insurance voucher program, but opposes to increase the participation of poor seniors in the buy-in program.

The Congressional proposals also make provisions for seniors to apply for the buy-in by mail and for a streamlined application or request for application.

■ **Annual notices**

Many Members of Congress have proposed that the Department of Health and Human Services notify Medicare beneficiaries each year about the buy-in benefit; about the eligibility requirements for the benefit; and about where to apply for the benefit.

To date, HCFA has refused to commit to regular notices. In the 1992 *Guide To Health Insurance for People with Medicare*, developed jointly by HCFA and the National Association of Insurance Commissioners, the buy-in is not mentioned until page 19.

■ **Toll-free number, outreach**

Many Members of Congress are asking for a toll-free number to call for information about the buy-in benefit. Several Congressional proposals authorize outreach programs to identify and enroll eligible persons. To date, HCFA has refused to act on these proposals.

■ **Retroactivity**

Many Members of Congress have recognized the inequities that have resulted from the lack of information about the buy-in benefit. Some Members have proposed that beneficiaries who newly learn about the buy-in benefit and apply within a specified enrollment period be eligible for retroactive benefits as if they had applied when first eligible.

In addition, many Members have recognized that QMBs should be treated the same as other categories of Medicaid beneficiaries and be allowed to get benefits retroactive to three months from the date of application.

HCFA opposes these proposals.

■ **Using providers to reach eligible seniors and using presumptive eligibility**

A potentially effective way of reaching eligible QMBs is when they are seeking medical care and incurring medical expenses at a doctor's office or a hospital. Many of the Congressional proposals recognize the importance of providing better information to potential QMBs through providers.

Recently, Congress has sought to increase the numbers of pregnant women getting Medicaid benefits by allowing providers to provisionally enroll likely beneficiaries (a procedure known as "presumptive eligibility"). The potential beneficiary then has 60 days to file a formal application. Members of Congress have proposed that the numbers of QMBs be increased by allowing providers to presumptively enroll potential QMBs.

To date, HCFA has not involved providers of health care in systematic QMB outreach efforts by, for example, sending notices for posting in offices. Moreover, HCFA opposes the use of presumptive eligibility for likely QMBs. These are other examples of strategies that President Bush proposes as part of providing vouchers under his Comprehensive Health Reform Program, but opposes for the poor elderly.

■ **Part A enrollment**

HCFA can identify approximately 337,000 individuals who do not have Medicare hospitalization benefits, but are eligible to have the Medicaid program pay their Medicare Part A premiums (\$192 a month). These are generally very low-income seniors or persons with disabilities who do not have enough of a work history to be automatically eligible for Medicare hospitalization benefits. Many states are not providing these very low-income persons with the more comprehensive Medicare hospitalization benefits. One key Congressional proposal would clarify that it is mandatory for states to buy QMBs into Medicare Part A, if they do not already have the coverage.

■ **Training**

HCFA should develop a training manual and program for each state to instruct Medicaid eligibility workers about the QMB program. Washington State, for example, trains its workers on the program, how to identify potential QMB-eligible, how to enroll these individuals, and how to implement the benefit. The success of Washington's program is evidenced by its 100% participation rate in the QMB program.

CONCLUSIONS

In addition to taking these specific steps, the Department of Health and Human Services must design and implement a comprehensive outreach program to provide all eligible Medicare beneficiaries with buy-in benefits. SSA has been engaged in a similar effort to get SSI benefits to poor seniors and persons with disabilities. It is our strong belief that this benefit will become a reality for those eligible only if there is a concerted effort within HHS to identify and reach eligible individuals and enroll them in the program. This means that, in addition to efforts to notify potentially eligible individuals, the Department must take steps to ensure that the application itself is as simple as possible to complete and that poor beneficiaries can apply as many ways as possible -- over the phone, in their homes, at senior centers, and at Social Security offices. We look forward to working with the Department to design such an effort.

Thank you again for the opportunity to present our views and findings on the Medicare buy-in with you.

Chairman JACOBS. Thank you, Mr. Pollack.
We do exalt quality, not necessarily quantity.
The next witness, please? Mr. Schulder.

**STATEMENT OF DANIEL J. SCHULDER, DIRECTOR OF
LEGISLATION, NATIONAL COUNCIL OF SENIOR CITIZENS**

Mr. SCHULDER. Thank you, Mr. Chairman.

My name is Dan Schulder, and I represent the National Council of Senior Citizens.

We, too, have read the good work of Families USA, and we believe that the figures in the Families USA report accurately reflect the levels of unserved persons, and the thousands of dollars that Ron Pollack has talked about that goes into paying Medicare bills would be better spent on rent and food and prescription drugs and the other needs of low-income persons.

We also believe that the State and Federal efforts to notify persons of the QMB benefits have been perfunctory and misdirected.

Just yesterday in the mail, it so happened we received this HCFA packet of information. It came just yesterday in the afternoon mail and just in time for delivery just before this hearing. And in this packet, there is information on public service announcements, notification to nonprofit organizations, et cetera. But again, it is a public relations approach rather than the kind of on-the-turf approach that we need.

Several years ago when I worked for Governor Schapp in Pennsylvania, I ran an SSI outreach program, and I am familiar with the difficulty of using mass media alone, advertisements in newspapers and magazines. They do not work.

What does work is person-to-person contact, the family friends, the neighbors, the spouses of persons who may be eligible. That is the most effective way in which that information about benefits can be transmitted.

Incidentally, back in Pennsylvania, we used title 20 of the Social Security Act, the information and referral authority, to spend some of the money to go out and find persons who are eligible for SSI. But again, just using agencies, even the best of the nonprofit agencies in the local communities, the welfare agencies, did not work. The membership groups, the churches, the person-to-person approaches worked best.

Mr. Chairman, we are concerned, as you, about the overburdening of Social Security offices in processing and bringing to determination QMB applications, and we believe that until Social Security off budget, until there is an adequate of administrative funds for the Social Security Administration, we would like to see the Social Security offices accept the applications, fill them out, but then forward the final determination of those QMB applications to the State offices.

But we also believe that Social Security should continue to inform potential applicants annually, if not more frequently, of their benefits under this program. We suggest that we take a look at the explanation of Medicare benefit forms, so that somewhere on that form, which some of us do try to read, we might have more information on QMB.

We also agree with the proposals and legislation to provide State agencies and nonprofit groups and organizations, like our own, with roots in the low-income community with funds to run outreach programs on a person-to-person basis. We think that is the way to do it.

We also would like to involve health care providers in providing information to beneficiaries. Hospitals, doctors, local clinics, all of them should be provided with information in many languages, pre-application forms if we can get them done, so that those persons can directly—those who are treating potential beneficiaries of QMB—provide them with the information to sign up for the program.

We would like to see more flexibility in the application process. We know State agencies are overburdened, as are Federal agencies, in terms of going out to people's homes and using the phone. But we really think that the Federal Government, as part of its agreement with the State agencies, should require them to use the telephone, to use mail applications, and, in fact, to go out to homes for persons who cannot complete the applications because of disability.

Finally, we suggest that things like title V of the Older Americans Act, the senior community Service Program, is an example of where you can find persons who are potentially eligible. That program now employs 62,000 persons at any one time, low-income persons at 125 percent of poverty or less. About 100,000 persons go in and out of that program every year, and 200,000 to 300,000 persons come in and apply for that program.

We screen our applicants to that program for QMB benefits. We have found many such persons who are eligible, and we try to bring them to the local offices. We think that ought to be done throughout that program and across the country. We think that every senior center ought to have the capability of screening for QMB benefits, as should every 202 housing program. They are there. They are available. We can make that happen.

Last, Mr. Chairman, we believe that H.R. 3473 is an appropriate vehicle to carry these things through. We just think it's indecent that people have to spend their money, as has been described here already, for a decent level of medical care. This is a matter of simple justice, and we think you can take care of it and do it now.

[The prepared statement and attachments follow:]

TESTIMONY OF DANIEL J. SHULDER, DIRECTOR OF LEGISLATION
NATIONAL COUNCIL OF SENIOR CITIZENS

Good morning Mr. Chairman, members of the subcommittees. It is a pleasure to be here today. My name is Daniel J. Scholder. I am the Director of the National Council of Senior Citizens' (NCSC) Department of Legislation. NCSC represents over five million older Americans nationwide through our 5,000 affiliated clubs and State Councils. The National Council was founded in 1961 to lead the fight for Medicare. After its enactment--an event we considered the first step in the creation of a universal national health care system--the Council turned to other advocacy issues as well as continuing our fight for national health care. These issues include, but are not limited to, Medicare improvements, including the Qualified Medicare Beneficiary program, Social Security and retirement income, housing, civil rights, transportation, and employment programs for older citizens.

As a part of the Catastrophic Health Insurance Act, the Congress created the Qualified Medicare Beneficiary (QMB) program. This program is for seniors over the age of 65 who currently fall below the federal poverty line and are not Medicaid eligible. For these individuals, Medicaid is supposed to "buy in" to the Medicare program and pay their deductibles, co-payments and premiums. Starting next year the program will pay the premiums of those who live at 110 percent of poverty, and in 1994 those at 120 percent.

The QMB program has been and remains a legislative priority of the National Council. In 1987, we were actively involved in the creation of the program and in 1989 we fought for its survival. We applaud Congress for creating the program and for realizing it was too important to kill as part of the Catastrophic repeal struggle.

Yet, our expectation of action by our government to respond to the needs of low-income seniors was quickly replaced with frustration at an Administration which rapidly made it clear that it was not interested in making minimal efforts to contact and enroll those who are eligible for the program.

The National Council of Senior Citizens has taken steps to reach out to potentially eligible citizens. We have run numerous articles in our newspaper, Senior Citizens News, (see Attachment A) which goes to our national membership. We also inform those who apply for our Senior Employment Program as a part of Title V of the Older Americans Act about the program. Many of our state affiliates have conducted outreach programs. For example, Arkansas Seniors Organized for Progress has put together a packet of materials (see Attachment B) which they distribute widely across the state. Also, Massachusetts Senior Action has conducted outreach programs to find those who might be eligible and assist them to apply (see Attachment C).

In spite of these efforts and the efforts of groups like ours, Mr. Chairman, only a small portion of those eligible sign up for the QMB program. According to our estimates and a report released nine months ago by Families United for Senior Action, only half of those eligible are enrolled in QMB. This means that large numbers of poor seniors are still paying for supplemental insurance and/or their Part B premiums, co-payments and deductibles. This is money they could better spend on prescriptions, rent, heat, food, etc.

There are several reasons why voluntary efforts by NCSC and others have not been as successful as they could be. The main reason is that the Administration has, at best, a perfunctory interest in promoting this program. In the summer of 1989, notices were mailed to lower-income Social Security beneficiaries. On January 19, 1992, the Health Care Financing Administration (HCFA) sent out another notice urging low-income recipients to contact their state Medicaid agency, social service office or welfare office. We are not aware of any other efforts undertaken by HCFA to stimulate effective outreach.

A second reason for the current failure is that state agencies have also done little or nothing. In this time of very tight budgets, states have few incentives to find someone who may be QMB eligible. In fact, some states have actually tried to reinterpret the statute to save money. The State of New York recently lost a court case because they were only reimbursing physicians at the Medicaid rate unless Medicare's rate was lower. They were not reimbursing the 20 percent Medicare co-payment at all.

There is also some confusion as to where someone can go for information. Since the Social Security Administration (SSA) does not take applications, they have not trained staff how to properly respond to QMB inquiries. At the same time, state welfare offices have also not been fully trained, so in many cases people have to make myriad phone calls before finding anyone who knows the program actually exists, yet alone knows enough to be able to tell someone how to apply.

Groups like ours are stymied by an inability to take or help individuals fill out a basic preapplication form to help determine eligibility. Once we find someone who appears to be eligible, the best we can do is to make an appointment for them at their local social service office and encourage them to go. Preapplication forms would materially assist such persons to secure eligibility determinations more quickly.

Finally, health care providers have not been systematically provided with information about the program and are unable to assist those they feel might qualify. For these reasons, low-income seniors are finding that there is no so-called safety net at all.

Mr. Chairman, what we see is a systemic failure of will, resources and planning to achieve the objective of securing modest financial protection for the nation's poorest citizens.

What can Congress do to responsibly increase the number of people enrolled in QMB? There are four key steps: First, SSA and HCFA must communicate directly with millions of older Americans. They are the ones who can most easily identify and contact low-income Medicare beneficiaries. Second, the application process needs to be improved. Congress needs to eliminate the stigma of applying at the local "welfare office." Third, groups like ours need to have help in expanding our efforts. We need resources to complement expanded public efforts to reach out to eligible persons. Finally, since health care providers are most likely to come into contact with low-income Medicare beneficiaries, they, too, must be provided with the tools to help their patients secure basic rights.

Mr. Chairman, the National Council has developed a series of recommendations which we would like you and this Committee to examine before adopting any QMB legislation.

- Accept applications at Social Security Administration offices.

Beneficiaries should be able to apply at SSA offices as well as their local social service offices. This will increase access and eliminate any stigma associated with visiting a "welfare office." Eligibility for QMB is based on the rules for SSI and Medicaid, which Social Security already handles in thirty states. If an applicant is found to be ineligible for SSI, but eligible for QMB, they should be able to apply at the SSA office rather than being sent to another location. Persons visiting SSA offices in regard to retirement, disability, and Medicare benefits should be screened for QMB and encouraged to apply if eligible.

Mr. Chairman, we understand and share your concern about placing a heavier administrative burden on SSA than they can handle. We share your concerns about staffing levels and the current inadequacy of the system to process basic benefit applications. We are only advocating that SSA offices accept the

applications, not process them at this time. We would propose that until SSA administrative costs are taken off-budget and SSA staff levels returned to adequate levels, that the applications be forwarded to the state social services offices for processing and final determination of eligibility.

- Mail notices to all potentially eligible seniors and persons with disabilities.

Low-income Medicare beneficiaries who may be eligible for QMB should be notified by the Department of Health and Human Services at least once a year. This could be done through a notice in Social Security checks or with notices of Medicare Part B premium increases. This is especially true as the eligibility requirements change over the next two years. Perhaps something about QMB could be added to the Medicare EOMB forms. Also, HCFA needs to take a greater role in informing the states about this important program.

- Provide grants for QMB outreach.

Funds should be made available for QMB outreach by state agencies, AOA-funded agencies, and nonprofit membership-based senior organizations with roots in the community. Because the income and asset eligibility limits for QMB are higher than for SSI and Medicaid, efforts to promote QMB also reach people who are eligible for SSI and Medicaid. Some people who would not respond to an SSI promotion, because their check would be so small or because they have been denied benefits in the past, might respond to a QMB promotion which demonstrates enhanced financial incentives.

- Involve health care providers in outreach efforts.

Health care providers need to have the tools to notify their patients about the QMB program. HCFA should supply providers with materials they can use, such as posters, sample bill stuffers, brochures written in understandable language with translations available, as well as basic information about the program. Ideally, they should be provided with preapplications to help determine if a patient is eligible. It is in the interest of the providers that QMB eligible persons are assisted to claim benefits.

- Increase flexibility in the application process.

Allowing applications to be filed without an office visit will increase access for people with disabilities, the frail elderly, and those who lack transportation. If groups such as ours could have a preapplication form available, we would be able to take down the information and bring it to the proper state agency. That agency should then be required to contact the individuals who were determined to possibly qualify for the program. The agency could then take an application over the phone or mail full applications so that someone does not have to leave home. We would also expect that agency to provide for physical visits to the homes of applicants if that is necessary to complete the process. Although this practice does not comply with state Medicaid policy, it works well for the applicants.

- Screen applicants and participants in other aging and disability programs.

All applicants and participants in aging and disability programs should be screened for eligibility for QMB, SSI/ Medicaid, and other programs. For example, the Senior Community Service Employment Program (Title V) has 62,000 job slots filled by people with incomes below 125 percent of poverty. With turnover, 100,000 are employed during the course of a year. Applicants can total 200,000 and they all have to be screened to determine income eligibility. While the National Council, with the second largest Title V program, is doing this, there is no reason that the other programs could not as well. We are also screening our tenants at NCSC-sponsored Section 202 apartment buildings. Congress should also require QMB outreach to the millions of persons using Older Americans Act-supported services.

This seems like a daunting task, Mr. Chairman, but the solution for most of our problems is already in front of us. The National Council has already endorsed Representatives Moody and Kostmayers' bill, H.R. 3573. We also support Senator Riegle's S. 1574. The Moody/Kostmayer bill would:

- 1) Require HCFA to mail annual notices with a toll-free hotline;
- 2) Develop posters and other visual aids for beneficiary groups and health care providers to help publicize the program;
- 3) Require SSA offices across the nation to accept QMB applications and forward them to the state social service office. It would also require states to accept applications by mail;
- 4) Require HCFA to create a preapplication form to aid local groups to help determine if someone may be eligible;
- 5) Establish a three-month retroactive eligibility; and
- 6) Provide outreach grants so groups like ours may expand their efforts.

Mr. Chairman, the National Council considers H.R. 3473 to be the responsible solution to our problem. We urge you and your colleagues to mark it up as quickly as possible so that low-income citizens will no longer be denied their basic right to decent health care without indecent demands on their meager resources. This is surely a case of simple justice that we can do something about.

Thank you.

Attachment A

SEPTEMBER, 1991
VOL. 8 • NO. 361
WASHINGTON, D.C.

Senior Citizens



News

**She May Be
Eligible for
Medicare
Aid . . .**

**But Does
She Know
About It?**

(See Story on Page 8)



Elderly Not Told About Medicare Help

The National Council of Senior Citizens, along with a number of advocacy groups, has stepped up its demands for action on helping the elderly poor with their Medicare costs.

Representatives from NCSC's Legislative and Information Departments recently met with government officials in charge of Social Security and Medicare to press them to do more to inform low-income persons about a program that pays Medicare premiums and other Medicare-covered out-of-pocket health care costs.

NCSC pointed out that, even though the program—known alternately as Medicare Buy-in or the Qualified Medicare Beneficiary Program (QMB)—took effect in January, 1989, most eligible elderly have never heard of it and are still paying for health costs that are supposed to be paid for by Medicaid.

In at least two states, Arkansas and Massachusetts, NCSC affiliates have been trying to fill the QMB information gap themselves, while continuing to pressure officials to do more on this. (See Health Column, page 12.)

Testifying before the Senate Special Committee on Aging on July 24, Scott Holladay, Executive Director of Arkansas Seniors Organized For Progress, told the panel that "Lack of information about

QMB seems to be the biggest barrier to enrollment."

Another barrier, he said, is the need to apply for it at a "welfare office," which many older people are reluctant to do "because of bad experiences in

the past, or the stigma." He recommended that persons visiting Social Security offices in regard to retirement, disability, and Medicare benefits be told about QMB and encouraged to apply, if eligible.

For QMB Aid

If you're receiving Social Security benefits because you're 65 or over or disabled, and you meet certain income and resource tests, you may qualify for assistance in paying your Medicare out-of-pocket costs. These costs include the Part B medical insurance premium, (\$29.90); the deductible on doctor bills (\$100) plus the 20 percent co-payment on these bills; and the deductible for a hospital stay (\$628).

Individuals are eligible if they have an annual income under \$6,620 and own less than \$4,000 in assets (not including a home, car or burial plot.) Couples are eligible with incomes under \$8,880 and assets under \$6,000.

For more information, contact your state or local welfare, social services or public health agency and ask about the Qualified Medicare Beneficiary program.

Legislation recently introduced by Sen. Donald W. Riegle, Jr. (D-Mich.) addresses the most serious problems outlined by Holladay, with solutions along similar lines. S. 1574 would require the Department of Health and Human Services (HHS) to begin a more vigorous outreach effort on QMB, including notices on a regular basis to potential beneficiaries; distribution of flyers and application forms to physicians' offices and medical facilities; and creation of special grants for face-to-face counseling of older people concerning Medicare and Medicaid benefits. S. 1574 also calls for a refund for seniors or disabled persons who were eligible but did not apply for benefits. This is among the demands being pressed by the Massachusetts Senior Action Council.

NCSC Executive Director Lawrence T. Smedley said the Riegle bill was needed because HHS and state agencies had "fallen far short of reasonable levels of effort to reach and notify more than two million seniors who qualify but who have not been brought into the QMB program."

Guest Editorial

Ensuring Health Coverage For the Aged Poor

By Senator Donald W. Riegle, Jr. (D-Mich.)

Three years ago Congress acted to protect low-income seniors and disabled citizens from the costs of premiums, deductibles, and co-payments under the Medicare program. The Qualified Medicare Beneficiary Program (QMB) was supposed to be implemented by the Department of Health and Human Services (HHS) and the states beginning in 1989.



Sen. Riegle

Unfortunately, fewer than half of the people believed to be eligible for this benefit are getting it. In my home state of Michigan, over 70,000 seniors are eligible but are not receiving the benefits under the QMB program.

Two years ago, together with many of my colleagues, I asked HHS Secretary Sullivan to notify beneficiaries and fully implement this important program. We now know, however, this work was not adequately done. Therefore, last month we wrote another letter calling on the Secretary to immediately design a program to seek out, notify and enroll seniors and disabled persons eligible for the program.

On July 26, 1991, I introduced comprehensive legislation, S.1574, the Medicare Enrollment Improvement and Protection Act of 1991, to improve enrollment in the QMB program through better outreach and notification and provide for a refund of premiums and other cost-sharing payments for low-income seniors or disabled persons who were paying more than required for Medicare coverage. The bill is supported by many organizations including the National Council of Senior Citizens, Families USA, National Association of Area Agencies on Aging and many others.

To increase the public's awareness of this benefit, S.1574 requires HHS to mail information at least annually to Social Security beneficiaries whose incomes qualify them, and to supply notices to physician offices and medical facilities for posting. A simplified application form would be developed which, when completed by a low-income Social Security beneficiary, will enable HHS to begin the process of determining eligibility.

To make it easier to apply, Social Security offices—not just welfare offices—would provide and assist with applications. Grants would be available to state area agencies on aging, senior centers, and other community-based organizations to locate and advise potentially eligible Medicare beneficiaries. And a toll-free phone line would make information even more readily accessible.

Refunds for eligible beneficiaries are not permitted under current Medicaid rules for QMB-eligible individuals. They often incur medical costs before they are found eligible—even though their incomes would have qualified them for the benefit. S.1574 would rectify those situations. And for those people who would have been eligible but didn't know about the benefit, Medicaid would be required to refund cost-sharing expenses back to January 1, 1991.

If you are interested in finding out if you qualify for benefits under the QMB program, you can contact your State Medicaid office, local Social Security office, or Member of Congress for assistance.

Low-income seniors and disabled citizens, especially those with serious medical problems, have a hard time meeting basic needs, such as food and rent. Congress intended to relieve some of their financial burden by alleviating their costs for Medicare. It's time we ensure they receive this relief.

Attachment B

QMB - a free Medicare supplement for low-income Medicare beneficiaries

The Qualified Medicare Beneficiary (QMB) program helps low-income Medicare beneficiaries with their health care expenses. If you are eligible, QMB will pay your:

- Medicare Part B premium - \$29.90 per month in 1991
- \$100 per year Part B deductible, and Part B co-payments
- \$628 hospital deductible, plus any co-payments for hospital care

To be eligible, you must meet these requirements:

1. You must be 65 or older, or blind, or disabled, and enrolled in Medicare Part A (hospital insurance).
2. If you and your spouse do not work, your total (gross) monthly income must be no greater than: \$571.66 for an individual, or \$760.00 for a couple. (These income limits effective April 1, 1991.)

If you have Medicare Part B, be sure to count your \$29.90 Part B premium that is deducted from your Social Security check each month. It is part of your income.

3. If you or your spouse work, you might qualify even with a higher income, because much of your earned income (wages, salary, or other payments for work) will not be counted toward the limit.
4. Your resources (assets) must be no greater than: \$4,000 for an individual, or \$6,000 for a couple.

Resources include cash or money in the bank, real estate, business investments, and other possessions. Your home, your household goods, and one car (valued at \$4,500 or less) are not counted. Burial insurance and burial spaces valued at up to \$1,500 are not counted.

If you already have both Medicaid and Medicare, you do not need to apply for QMB.

Apply for QMB at the Arkansas Department of Human Services office in your county. Call first to see what documents you need to take with you.

**Arkansas Seniors Organized for Progress (ASOP) 661-1401
1408 Rebsamen Park Road Little Rock, Arkansas 72202 Revised 6/91**

Attachment C

The Boston Globe

SATURDAY, JUNE 29, 1991

Seniors seek refund of charge deducted from checks in error

By Dolores Kong
GLOBE STAFF

Nearly 20 senior citizens and activists protested to officials at the John F. Kennedy building yesterday, demanding that federal officials correct a wrongful Medicare deduction from Social Security checks.

At issue was a monthly \$29.90 deduction from low-income elderly's checks to cover Medicare premiums that the government should have picked up, but about which seniors have not been adequately notified.

"We're not begging. We're asking for what we're entitled to," said Oscar Farmer of Roxbury, after he and other protesters from the Massachusetts Senior Action Council talked their way into meeting en masse with federal health officials, rather than limiting their group to only five, as the police had instructed. "We have to cut through the red tape."

The protesters demanded that seniors be notified; that the unnecessary payments be refunded; and that seniors be allowed to apply for the "qualified Medicare beneficiary" program through the Social Security office, a bureaucracy with which they are familiar, rather than the local welfare or Medicaid office.

"These are the demands and I

**'We're not begging.
We're asking for
what we're
entitled.'**

OSCAR FARMER

don't think they're unreasonable," said Manny Weiner, president of the council.

Federal health officials Sidney Kaplan and Peter Toland said they could make no promises but would forward the demands to the appropriate people.

The Families USA Foundation, a Washington-based advocacy group, reported last week that the deduction was made despite Congress' intent that Medicaid cover the Medicare premium, as well as the cost of Medicare deductibles and coinsurance. The foundation's report estimated that the unnecessary payments have been adding up as much as \$1.8 billion nationally and \$34 million a year in Massachusetts.

Medicare is the federal health insurance program for people who are 65 and older or disabled, while Medicaid is the joint federal-state health insurance program for the poor or those who become poor because of medical expenses. The \$29.90 a

month is the Medicare premium for such things as doctors' bills and ambulances.

One bureaucracy's red tape is difficult enough to cut through, but two bureaucracies are involved in this issue and federal and state governments.

While federal officials say seniors have to apply to have the \$29.90 picked up through the state Medicaid or welfare office, state officials say it would be easier for the federal government to notify seniors of their eligibility when it mails them their monthly Social Security checks.

Locally, one 78-year-old Burlington woman said she has gotten so frustrated calling half a dozen government numbers that she will now talk with a local senior citizen organization about it.

Mary Claire Kennedy, spokeswoman for the Massachusetts Department of Public Welfare, said a special notice was sent out Wednesday to all welfare offices, alerting them that there will be increased interest. Client services at 1-800-841-2900 may be able to determine eligibility over the phone.

An elderly person who has a monthly income of \$522 or less, after medical expenditures and other allowable deductions, and \$4,000 or less in assets, can qualify.



TAKE NOTE: Della Webb of the Massachusetts Senior Action Council holds an enlarged version of the letter she and other members of the council delivered to the Department of Health and Human Services yesterday at the John F. Kennedy Federal Building.

Seniors send message on Medicare benefits

By ZACHARY R. DOWDY

A dozen members of the Massachusetts Senior Action Council marched to the John F. Kennedy Federal Building to deliver a letter urging administrators at the Department of Health and Human Services to alert seniors of Medi-

care "buy-in" benefits.

"Basically we feel information on the Medicare program has not been made available to seniors," said Manny Weiner, president of the council.

The law diverts Medicaid money to pay premiums deducted from Social Security checks, de-

ductibles and co-payments for single seniors with incomes less than \$420. The ceiling is \$3,600 for couples.

Weiner estimates at least half the Bay State's 44,000 eligible seniors do not know they qualify since they have not applied for benefits.

Staff photo by Joe H.

Chairman JACOBS. Thank you.
Ms. Archuleta.

STATEMENT OF LENA ARCHULETA, MEMBER, BOARD OF DIRECTORS AND NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. ARCHULETA. Good morning.

I am Lena Archuleta from Denver, CO. I am a member of the board of directors and the national legislative council of AARP, and we very much appreciate the opportunity to testify today.

Prior to the enactment of the QMB Program, many beneficiaries were caught in a cruel catch-22, eligible for Medicare, but with the Government deduction of \$31.80 from their checks each month, and unable to receive benefits because they could not afford the rapidly increasing out-of-pocket costs.

AARP has strongly supported the QMB Program from the outset. But far too many low-income elderly adults continue to pay health care costs that should be paid under the QMB Program. Tragically, millions of poor elderly people are not receiving the protection the law provides, because they do now know about the benefits to which they are entitled.

Correspondence that AARP has received from our members confirms that very serious problems persist, reflecting confusion about the program, lack of information and responsiveness from State employees, and great frustration in attempting to apply for these benefits.

On more than one occasion, our members have been informed that the QMB Program did not even exist in their State.

Both the Health Care Financing Administration and the States share responsibility to ensure that eligible persons receive QMB Program protection. At the Federal level, every effort should be made to identify QMB eligibles whose monthly Social Security checks are being reduced by the amount of the Medicare premium, so that steps can be taken to end this practice.

Further, much more can and should be done to develop a QMB monitoring system which should be used to develop strategies to increase participation.

We also believe that consideration should be given to the development of a presumptive eligibility process in which certain providers could receive payment to cover Medicare cost-sharing amounts for a short period of time, pending a formal determination of eligibility.

Since QMB eligibility requirements are uniform, we also support requiring States to use a simple, standardized application form.

In addition, we believe that SSA offices should be required to accept QMB applications. We recognize, however, that the new responsibilities would place a greater strain on already thin SSA resources and that Congress needs to fund the agency adequately, so it does not shortchange any part of its mission.

AARP supports the creation of funding of grants for State and local outreach programs to support technical assistance, training, media campaigns, and so forth. Other outreach initiatives that should be pursued are included in my written statement.

Last year, AARP was pleased to participate in a HCFA working group to help develop strategies to improve outreach to potential QMB's. Although some initial progress was made, little has actually been accomplished to date. We encourage HCFA to act quickly on the efforts discussed in these meetings.

The problem of outreach in the QMB Program is symptomatic of the outreach problems throughout all low-income programs. AARP has taken the lead in sponsoring community-based outreach programs, seminars for advocates, and counseling programs around the Nation to inform low-income persons about the availability of these benefits. We discuss these efforts and the lessons learned from them in our written statement also.

The problems with this benefit underscore much of what is already known about such means-tested programs: The persistence of significant access barriers, because of State budget problems, complex and confusing eligibility, and application procedures and the stigma with the association of means-tested program coverage. These further illustrate the problems of our patchwork system, and we believe that we really need comprehensive health care reform for persons of all ages and incomes to meet these problems.

Much can and must be done to improve the outreach of the QMB Program. The State and Federal governments, along with community-based organizations and individuals, need to cooperate on these. Ultimately, however, we need to do something about comprehensive system reform of our entire system.

We look forward to working with you and the administration, and other Members of Congress to achieve these objectives.

Thank you.

[The prepared statement and follows:]

TESTIMONY OF LENA ARCHULETA
AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning. I am Lena Archuleta from Denver, Colorado. I am a member of the Board of Directors and the National Legislative Council of the American Association of Retired Persons (AARP). The Association very much appreciates the opportunity to testify at this important hearing.

Far too many low-income older adults are paying health care costs that should be paid for under the Medicaid "Buy-In," or Qualified Medicare Beneficiary (QMB) program. This hearing provides a welcome opportunity to focus on the problems of implementing the QMB program and to begin to identify strategies that will ensure that low income Medicare beneficiaries receive the assistance in paying their health care bills that the law intends.

This testimony discusses the QMB program itself, the implementation and outreach problems in the program and recommendations for improving outreach and program participation. It also describes some of the efforts AARP has undertaken in this area. Lastly, I will discuss why the problems we are experiencing with the QMB program are symptomatic of a means-tested health care program such as Medicaid, and why the ultimate goal should be a new comprehensive health and long-term care system that provides needed coverage for all individuals, regardless of age or income.

The QMB Program

Congress created the QMB program to prevent the extreme financial hardship and barriers to access that arise when low-income individuals must pay Medicare's premiums, deductibles and coinsurance in order to receive services. Prior to this protection being made available, many low-income older persons were caught in a cruel catch 22: eligible for Medicare but unable to receive benefits because they could not afford rapidly increasing out-of-pocket payments.

It is the 20 percent of the Medicare population (approximately 7 million enrollees) lacking either Medigap or Medicaid coverage who are at greatest risk of a high cost acute care experience. And, within this group, those even more vulnerable are the approximately 3.5 million enrollees who happen to be very old, very frail, and poor/near poor. These are the needy Americans the QMB program was designed to help.

Under the QMB program, Medicare beneficiaries with income below the federal poverty line currently are eligible to receive Medicaid coverage of Medicare's premiums, deductibles and coinsurance. Beginning in January, 1989, Medicaid programs--using combined state and federal revenues--were required to pay the Medicare premiums, deductibles, and copayments for beneficiaries with incomes at or below 85 percent of the poverty level. The Omnibus Budget Reconciliation Act of 1990 (OBRA) expanded this protection. Beginning in January 1991, Medicare beneficiaries with incomes at or below 100 percent of the federal poverty threshold became eligible for the QMB program. This OBRA90 change accelerated the phase-in established in the 1988 legislation by one year.

Additionally, by 1993, Medicare enrollees with incomes between 100 percent and 110 percent of the federal poverty threshold will have their Medicare premiums (but not deductibles or coinsurance) paid by Medicaid. By 1995, this protection will be extended to Medicare enrollees with incomes between 110 percent and 120 percent of poverty. AARP has strongly supported the QMB program from the outset as an important means of protecting poor and low-income older Americans against the skyrocketing costs of health care.

Outreach Problems in the QMB Program

Tragically, millions of poor elderly persons are not receiving the protection the law provides because they do not know about the benefits to which they are entitled. Correspondence AARP has received from our members confirms the very serious problems that persist. Since publication of an article in the AARP Bulletin about the QMB program approximately one year ago, we have continuously received letters reflecting confusion about the program, lack of information and unresponsiveness from state agency employees and great frustration in attempting to apply for these benefits.

The problems in state agency administration are illustrative. On more than one occasion, our members have been informed by Medicaid and other state employees that the QMB program did not even exist in their particular state. In far too many instances, we have received complaints that individuals who made inquiries were discouraged from making formal application because of previous denials of coverage, intrusive questioning or onerous forms. Even here in Washington, D.C., we were informed of an instance in which a Medicaid intake worker told an applicant that the QMB program "no longer exists." In short, the information we have received from various sources indicates that states are, at best, having difficulty implementing the program and, at worst, steadfastly refusing to acknowledge its requirements.

Problems of implementation at the federal level are also evident as has been shown by recent studies by the Families U.S.A. Foundation which revealed that the federal government continues to deduct the Medicare Part B premium of \$31.80 per month in 1992 from the Social Security checks of an estimated 2 million poor older persons who should not be paying anything under the law.

Initiatives Needed to Improve Outreach

The Health Care Financing Administration (HCFA) and the states share responsibility to ensure that eligible persons receive QMB program protection. Without question, both HCFA and the states must do more in terms of outreach. Some initiatives will require legislative action and some will not. Prior to enacting legislative changes, more accurate cost estimates and methods for financing such initiatives should be developed.

At the Federal level, every possible means should be used to identify those who are eligible for the QMB program but whose monthly Social Security checks are being reduced by the amount of the Medicare premium so that steps can be taken to end this practice. Much more can and should be done to develop and maintain a QMB monitoring system, drawing on both Federal and State data, that analyzes QMB program participation. This data should be used to develop strategies to further increase outreach and program participation. In general, means should also be explored to promote reliance on verification of income and assets by and across other means-tested programs such as the Food Stamp program to prevent duplication of effort and help remove an impediment to participation in a number of programs.

AARP supports legislation to require that HCFA create a toll-free 800 number for consumers to call for information on eligibility for the QMB program and how to apply. It is critical that operators be well trained to handle a variety of potential information requests. The current Medicare/Medigap line ostensibly is being used for this purpose. At this point, however, it essentially provides a referral service to another state or local number. It would be preferable for operators on the 800 line itself to have available detailed information on program eligibility requirements both orally and in writing, as

well as information on counseling and legal services programs who can provide direct assistance in application and appeals processes.

The Association believes that we should consider the development of a presumptive eligibility process in which certain providers could receive payment to cover Medicare cost sharing amounts for a short period of time, pending a formal determination of QMB eligibility, for providing medical treatment to low-income older persons. The process could be modelled after the Presumptive Eligibility for Pregnant Women provision currently available under the Medicaid program.

AARP supports the creation and funding of grants for state and local outreach programs to support technical assistance, training, media campaigns, materials and a wide variety of other initiatives.

The Association also supports efforts to simplify the application process in a consistent manner across states, since QMB eligibility requirements are uniform. Currently, the application forms themselves are often unduly complex and burdensome to fill out. States should be required to use a simple, standardized form. The straightforward form developed in West Virginia may serve as a good model for such deliberations. Similarly, states should be strongly encouraged to use the same name for the program to avoid the confusion that beneficiaries have encountered when they are told that the state does not participate in the program referred to.

In addition, we believe Social Security Administration (SSA) offices should be required to accept QMB program applications. These offices currently make Medicaid categorical eligibility determinations in 34 states. Frequent contact with low-income and elderly persons, together with the absence of a welfare stigma associated with SSA offices, should help contribute to an increase in QMB participation rates.

Other changes which would make it easier to receive benefits include stationing workers at external sites such as clinics and hospitals, providing workers for home visits when necessary, and facilitating transportation to local agencies.

The Association recognizes that added responsibilities would place an even greater strain on SSA's resources. They already are stretched thin given the backlog of disability benefit applications. Congress needs to fund the agency adequately so it does not shortchange any part of its mission to the American people.

Last year, HCFA formed a Working Group to help develop strategies to improve outreach to potential QMBs. AARP was pleased to participate in these meetings. Although some initial progress was made, the group has not met since December 3. As a result, little has been accomplished through these efforts to date. We encourage HCFA to act quickly on the initiatives discussed in the meetings of the QMB Working Group, including improving the Medicare/Medigap telephone hotline so that it can provide detailed information on the QMB program and developing and distributing, in final form, public service announcements, videos, information kits and brochures. We also hope that "consumer-friendly" documents can be developed with specific state and local contacts to call for details on applying for QMB benefits.

Other innovative outreach initiatives that should be pursued include:

- o Working with the provider and medical communities, who have frequent contact with Medicare beneficiaries, to

distribute educational materials, including showing videos in waiting rooms;

- o Developing formal links with LIHEAP, Food Stamp and SSI outreach networks and efforts;
- o Training minority and low-income older persons in the Title V network to assist in local outreach efforts;
- o Developing programs to assist large groups of persons in filling out complex forms--to complement one-on-one assistance; and
- o Requiring volunteer counselors in new federally-funded state health insurance counseling programs to do QMB outreach and assist with applications.

AARP Efforts to Improve Outreach in Low-Income Programs

The problem of outreach in the QMB program is symptomatic of the outreach problems throughout all low-income programs, including Food Stamps, Energy Assistance and Supplemental Security Income. AARP has taken the lead in sponsoring community-based outreach programs around the nation to inform low-income persons about the availability of these benefits. For example, we have QMB Fact Sheets available for distribution that have been translated into 8 languages. AARP has also conducted outreach seminars for advocates and volunteer-oriented counseling programs for older Americans. We discuss these efforts to help illustrate the kinds of activities individuals and groups can participate in to reach out to low-income persons in their communities.

Since 1990, AARP has launched several community-based outreach projects to address the problem of low enrollment for benefits in the Medicaid and QMB programs. These projects helped to educate older persons about the Medicaid and QMB programs generally, their eligibility requirements, and how to apply for benefits. Some of the most innovative outreach strategies were:

- o Extensive television coverage and the assignment of volunteers to help potential recipients to fill out the application forms in Cincinnati, Ohio;
- o Translation of materials into Spanish and the use of bilingual/bicultural outreach workers in Wichita, Kansas and Colorado;
- o A coupon for QMB information that resulted in over one thousand inquiries in Buffalo, New York; and
- o A weekend blitz in suburban Atlanta where workers distributed information at 23 community locations, such as banks, subway stops and beauty shops.

Some of the lessons we learned from these and other low-income beneficiary outreach projects include:

- o **Leadership by One Agency to Coordinate the Outreach Efforts.** It is crucial that one agency be willing to take leadership of such an outreach project for it to be successful.
- o **Coalition Approach.** A coalition of agencies working together provides the type of community effort necessary to reach the elderly poor.
- o **Variety of Outreach Methods.** No single method of outreach is adequate to do a complete job. Outreach should involve training, community education presentations, extensive use of the media, individual outreach and assistance on a one-on-one basis, and other special activities designed to accommodate local circumstances and resources.
- o **Involvement of Agencies Administering the Program.** An outreach project will be more successful if there is cooperation with the agencies administering the programs at the local level.

- o **Follow-up of Individuals Referred for Application.** There is a much greater chance of a successful application being filed if there is some follow-up by the agency referring the individual.
- o **Outreach to Minority Populations.** Special attention must be given to contacting those people who are not reached through the more traditional methods of outreach. This may include working with local media using the Spanish language television and radio stations, translating information sheets and using a bilingual outreach worker to answer inquiries.
- o **Documentation and Evaluation of Outreach Activities.** Efforts should be made to document and study outreach activities so that others can continue to do this type of work without "reinventing the wheel."

The Association would be pleased to share our relevant experiences and lessons learned in greater detail with interested parties. We currently have available materials designed to assist organizations and communities, who meet certain standards, in setting up effective outreach programs.

The Association has also operated since 1979 a consumer/beneficiary counseling program, known as the Medicare Medicaid Assistance Program (MMAP). Through this program, trained volunteers have contributed to QMB outreach efforts in a number of ways, including:

- o Identifying clients who could be eligible for benefits and helping them complete application forms;
- o Writing articles for weekly senior and community newspapers;
- o Making presentations to groups and discussing the QMB program on cable TV and radio talk shows; and
- o Assisting reporters with local stories on the QMB application process in their communities.

In addition, we have published four articles on the QMB program in our national publications over the past year. These have generated a large number of inquiries which, we believe, have lead to greater program participation.

The Need for Comprehensive Health Care Reform

The problems with this benefit underscore much of what is already known about such means-tested federal/state programs--the persistence of significant barriers to receiving benefits because of state budget problems, complex and confusing eligibility and application procedures and the stigma associated with receiving means-tested program coverage. These findings further illustrate the serious problems of our current patchwork system and the need for comprehensive reforms in our health care system for persons of all ages and incomes. We cannot solve the problem, as some have suggested, by merely expanding the current welfare-based Medicaid program--which does an inadequate job even of protecting the population it was designed to cover.

The Medicaid program, intended to serve as the "safety net" for both the acute and long-term care needs of low income families, is severely limited. Medicaid is under constant budgetary constraints, particularly at the state level, and this fact is surely responsible for some states' reluctance to enforce the QMB requirements. Additionally, Medicaid does not receive the broad public and political support granted to social insurance programs like Social Security and Medicare. The result is that in 1988, only 51.4 percent of the approximately 33 million Americans living below the federal poverty line were estimated to be enrolled in Medicaid.

AARP believes that comprehensive reform of our health care system must become a national priority if we are to achieve the goal of assuring access to quality care for all our citizens and to gain control of escalating health care costs. To achieve broad public consensus, continued public education is essential. AARP is making education a priority activity so our members will come to recognize that, even though they may have adequate health care coverage today, they could quickly become vulnerable to devastating acute and long-term care costs under our current system.

The Association knows that any comprehensive health care reform plan will be controversial and we have no illusions about a quick solution; but clearly, the 1992 elections offer an important opportunity to help solidify America's commitment to reforming our health care system. AARP and thousands of our volunteer leaders are helping to make health care reform a focal point of debate in the national elections.

In conclusion, much can and must be done to improve outreach activities on the QMB program. The state and federal governments, along with various community-based organizations and individuals, must work in close cooperation to ensure that low-income older persons receive the assistance they so desperately need and are entitled to by law. Throughout these efforts, we must not lose sight of the fact that ultimately, in order to effectively protect persons of all ages and incomes from the skyrocketing costs of health care, comprehensive reform of our entire system must take place. We look forward to working closely with the Administration, members of Congress and state government officials to achieve this objective.

Chairman JACOBS. Thank you.
Ms. Nemore.

**STATEMENT OF PATRICIA NEMORE, STAFF ATTORNEY,
NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, DC.**

Ms. NEMORE. Thank you, Mr. Chairman.

I would like to endorse the comments that have been made by the other panelists on my panel this morning, and direct, in addition to my written testimony, direct your attention to a particular problem that is very troubling to me.

You mentioned earlier in the hearing this morning that you felt there was a way that people could become eligible for the QMB benefit, by purchasing Medicare rather than the normal way that people get part A by receiving title 2 benefits.

It is correct that that is a way of becoming a QMB and, in fact, HCFA, alone, has identified 360,000 people that it is able to identify from its own records who are entitled to have the part A purchased, and would therefore become QMB's as a result of that purchase, and for whom the purchase has not happened.

For 215,000 people in 16 States around the country, that option will be foreclosed next Tuesday, and the reason is that the Medicare law limits people from purchasing Medicare part A except at a particular enrollment time and annually, between January and March of each year. The eligibility, then, begins in July of that same year.

For the 215,000 people in the 16 States where that enrollment limitation is not waived under the QMB Program, they will not be able to be QMB's, to have the Government pay their Medicare until at least July 1993, if they are not enrolled by next Tuesday.

I would like to read those States and then suggest some ways that I think HCFA and SSA, and perhaps these subcommittees, could help to encourage as many people as possible to get enrolled by the March 31 deadline.

The States are Alabama, California, Colorado, Illinois, Kansas, Kentucky, Louisiana, Missouri, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Texas, Utah, and Virginia.

The part A benefit can be very important, because a lot of State Medicaid Programs have much more limited hospitalization coverage and, in fact, more limited coverage for rehabilitation in nursing homes than is available under Medicare. So this particular Medicare benefit is very important.

It is virtually impossible for poor individuals to pay the premium. It is \$192 a month—\$2,300 a year—for the part A premium. Obviously, paying for it is not an option.

What HCFA could do to meet the March 31 deadline is to allow people to call in to the Social Security offices and be given protective filing. That is a concept that is available to people in the SSI Program, a signature and application is not necessary. A call indicating your interest in the program is all that is necessary, and then within a certain time, the person needs to make the formal application. This could be done in the Social Security offices.

When people are given the protective filing, they would become conditionally eligible. This is a concept HCFA has adopted, to re-

solve the insidious catch-22, that you need to have part A in order to be a QMB, and yet you need the QMB payment to pay your part A premium, because you are a low-income person and cannot afford it.

What HCFA has said is, "We will have conditional eligibility. You are in part A, conditioned upon becoming a QMB and having your State pay the premium."

So people should be allowed to file protectively between now and next Tuesday and, in fact, get conditional eligibility.

Notices must go out to all Social Security offices immediately, making very clear—as someone said earlier—we need clear and brief notices about this program, so that when people call up to do this, they will get the correct action that is needed.

I do not know if it is possible, but certainly Congress might consider if there is a way to have the agency extend the March 31 deadline. It is a statutory requirement, but I know that a statutory deadline was struck down in a lawsuit on a similar type of benefit because no action had been taken by the agency.

Whether there is some way that the Congress could get health care financing to extend the March 31 deadline, I do not know.

I would recommend that HCFA and Social Security get on the phones immediately to all major media that they have been in contact with for PSA's, and get stories in the paper over the weekend, encouraging people to call in for protective filings by next Tuesday.

Chairman JACOBS. Ms. Nemore—

Ms. NEMORE. Yes.

Chairman JACOBS [continuing]. Your time has expired, but I was going to tell you that we have a copy of your statement here, and I think you have made some very useful suggestions—all the more useful because they are specific and apparently doable.

I intend to write to HCFA today or tomorrow, a letter including the suggestions that we consider the most salient of those possibilities. I do not think there is a chance in the world that Congress could change the deadline this year. There simply is not time. I just barely met another deadline the other day, did I not?

So we appreciate your contribution. I do intend to reflect that in the letter.

Ms. NEMORE. I would be very happy to work with your subcommittee staff, Mr. Jacobs.

Chairman JACOBS. Other than typing it out, I do not think I have any problems. We have your statement here, and the itemized suggestions, some of which I think are very practical and can be implemented instantaneously.

[The prepared statement and attachments follow:]

TESTIMONY OF PATRICIA NEMORE BEFORE THE SUBCOMMITTEES ON SOCIAL SECURITY, HEALTH, AND HUMAN RESOURCES OF THE HOUSE COMMITTEE ON WAYS AND MEANS ON OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY INCOME AND QUALIFIED MEDICARE BENEFICIARY PROGRAM

March 26, 1992

Thank you, Subcommittee members, for inviting me to testify this morning on outreach needs for the Qualified Medicare Beneficiary program. I am Patricia Nemore, a staff attorney at the National Senior Citizens Law Center here in Washington. The Law Center has been advocating on behalf of poor older people for 20 years. We are funded primarily by the Legal Services Corporation and the Administration on Aging to provide legal and technical assistance to attorneys and other advocates representing poor older people throughout the country.

The Law Center worked with Families USA and other organizations on the legislation that created the QMB mandate, and since the law was passed, we have been helping advocates get the benefit for their clients.

Background on the QMB program

In 1988, Congress mandated that all state Medicaid programs pay the Medicare premiums, deductibles and coinsurance for poor Medicare beneficiaries. These beneficiaries are referred to as Qualified Medicare Beneficiaries or QMBs. The mandate, which replaced a similar optional program enacted in 1986, was included in the Medicare Catastrophic Coverage Act of 1988 (MCCA) to ensure that poor old and disabled people would not lose the value of their Medicare benefit due to increased Medicare cost-sharing required by that law.

When the Medicare expansions contained in MCCA were repealed in 1989, the Medicaid portions were retained, including the QMB program. In 1990, again recognizing the heavy burden of Medicare cost-sharing on poor people, Congress accelerated the rate of phase-in for QMBs. Beginning in 1992, all states must pay all Medicare cost-sharing for old and disabled individuals entitled to Medicare Part A who have incomes at or below 100 percent of poverty and resources at or below \$4000. Additional cost-sharing is phased in through 1995, when Medicaid programs must pay premiums only for people with incomes up to 120% of poverty.

The QMB program included in MCCA was effective January 1989. Before that time, states were already paying Medicare Part B premiums for some or all of their Medicaid recipients under arrangements with the federal government known as buy-in agreements. States could also pay cost-sharing (such as deductibles and coinsurance payments) for their Medicare-eligible Medicaid beneficiaries, thus giving them greater access to services that were not covered by the state Medicaid plan. Although QMBs were defined in MCCA as people who were not otherwise eligible for Medicaid, shortly after MCCA's passage, the law was amended to include Medicaid beneficiaries who fell within the QMB financial eligibility standards in the definition of QMBs. Thus, the current QMB universe includes both people entitled to a full range of Medicaid services and people entitled only to have Medicaid pay their Medicare cost-sharing.

Federal outreach

Since 1989, neither HHS nor the states has done a vigorous job of outreach to identify potential QMBs and enroll those eligible. Families USA has done a superb job of bringing that problem to light and has testified about the most significant issues. I wish to focus on a few related matters that have a great impact on the availability of this benefit to low income old and disabled people.

A. Need for Correct Information

1. QMBs include disabled Medicare beneficiaries

We were shocked recently to receive a copy of a Social Security Administration one-page flier on the QMB program that stated clearly "Social Security Administration disabled beneficiaries under age 65 with Medicare are excluded -- QMB's MUST BE at least 65 years old." This is absolutely incorrect. All people entitled to Medicare Part A who meet the income and resource standards are eligible for QMB status. 42 U.S.C. §1396d(p). Although the Social Security Office of Public Affairs has told NSCLC that it has taken care of retrieving this misinformation, we do not know how broadly it was disseminated prior to being retrieved. Your subcommittees may wish to inquire of SSA and HCFA about this and ask that they take affirmative action in those areas where it was disseminated. (We know it came from Michigan, but do not have information about its use elsewhere.)

2. HCFA should use correct statement of income eligibility

Second, ever since HCFA began developing client information about the QMB program, we and others have urged them to make clear that the income limits are actually \$240 above the relevant poverty figure. This is true because eligibility is determined using SSI principles, including the allowance of a \$20 per month disregard of income. In 1989, in response to a request from members of Congress, HCFA did amend the figures used in its mailing to low income Title II recipients to reflect the higher limits. Since that time, however, it has returned to using the flat poverty figure, thereby possibly misleading eligible individuals to self-select out of seeking benefits.

3. HCFA should clarify that Part A is not necessary

HCFA's informational material also includes the statement that a person must have Medicare Part A to qualify as a QMB. While this is a technically correct reading of the statute, it fails to consider that states must purchase Part A for those low-income people who would then be entitled to QMB status. This, too, will cause people to self-select out of seeking benefits.

4. Clear information must be provided for SSA and Medicaid agency personnel to be informed about QMB

In addition to providing information that too narrowly describes those entitled to the benefit, HCFA and SSA have failed to require both SSA workers and state Medicaid agency personnel to be correctly informed about the benefit. Whenever the QMB program receives publicity, thousands of low income people call these offices to find out more about it. Advocates report to us that they are often told there is no such benefit, or the worker does not know what they are talking about. This need not be the case. In Tennessee, where a QMB coalition has been working for the past year or so to increase participation in the program, advocates tested their Medicaid offices by calling in with vague questions about having heard that the state might pay their Medicare premiums. These calls yielded 100% success in terms of the workers being knowledgeable about the program.

B. Need for Easy Application

The Social Security Administration has resisted taking QMP applications despite near universal calls from advocates that it do so. There is no good reason for SSA offices not to take applications, even if they do not perform the eligibility determination. We are totally sympathetic to and concerned about the service issues that have plagued Title II and SSI beneficiaries over the last decade due to personnel cutbacks and other problems in Social Security district offices. However, QMB applications need not be very different from SSI applications, which the offices are already handling.

QMB eligibility is determined in accordance with SSI principles. Although the actual standards for QMBs differ from those for SSI, the information needed is virtually identical. A one page QMB application, used by Tennessee, is attached to this testimony. A review of it reveals that the SSI application would need only a short, perhaps one-half page addition, to include information needed to determine QMB eligibility. For those QMBs not entitled to SSI, the agency could use just the single page. In Tennessee, this application can be mailed in to the Medicaid agency and eligibility can be determined without the individual ever leaving home. (The application can be mailed to the applicant as well; QMB fliers give an 800 number for interested people to call.)

C. Need for HCFA to enroll all QMBs it is able to identify

It is also shocking to discover that the Health Care Financing Administration (HCFA) is able to identify millions of individuals, most of whom are entitled to but who are not receiving full QMB benefits that the states are required to provide and that HCFA has done nothing about it. In a November 22, 1991 memorandum from HCFA's Director of Medicaid Management to the Deputy Chief Counsel, HCFA proposed three different strategies to enroll three different groups of QMBs. (A copy of the memorandum and the response to it has been supplied to the subcommittees.) General Counsel vetoed the proposal.

The first two groups HCFA identified consist of individuals for whom states are already purchasing Part B premiums but who are not entitled to free Part A. Nearly all of these individuals will be eligible as QMBs when they are enrolled in Part A, but the states have not yet enrolled them. Thus, these individuals do not get the advantage of Medicare's hospital and skilled nursing facility benefits.

Medicare Part A benefits are important, even for individuals entitled to full Medicaid benefits in their state. At least 22 states impose greater restrictions on hospitalization under Medicaid than exist in Medicare, either requirements for prior authorization or limitations on number of days covered.¹ Moreover, benefits for skilled rehabilitative services in skilled nursing facilities are more substantial under Medicare than in many states. Although state Medicaid programs are apparently required, under the Medicaid law, to provide rehabilitative services to the same degree that they are required under Medicare, advocates report significant barriers to clients receiving such services. Rehabilitative therapies often mean the difference between returning home after a hospitalization or remaining in a nursing facility for a long period of time.²

In its memorandum to General Counsel, HCFA's Office of Medicaid Management proposed to add these people, for whom the states are already paying Part B premiums, to the billing system for Part A premiums. It would then bill the states and allow them to purge from the rolls the few individuals who may not, in fact,

be entitled to QMB benefits.³ The mechanics of the proposed process work differently for one group of 34 states from another group of 16, depending on the type of billing system the state has with HCFA,⁴ but the result is the same: People entitled to the QMB benefit will start to receive it, at last -- three and one quarter years after the program became effective.

General Counsel has replied (nearly three months later on February 6, 1992) that HCFA cannot unilaterally add the QMBs to the billing system without the state's advance approval; HCFA, it says, does not make eligibility determinations for Medicaid. However, in many states, the Social Security Administration does make certain Medicaid eligibility determinations, under agreement with the state. At least in those states, SSA could make the QMB eligibility determination and add the names to the rolls (as HCFA is now ready, willing and able to do but for the General Counsel's veto).

General Counsel also raises the question of who will pay for the first month's Part A premium for those added to the rolls. This issue arises because of two provisions of the law. One is the definition of QMB eligibility, which includes the requirement that the individual be entitled to Medicare Part A. 42 U.S.C. §1396d(p)(1). The second is the definition of "medical assistance" in the Medicaid law, which provides federal money for Medicare cost-sharing beginning "after the month in which the individual becomes such a beneficiary." 42 U.S.C. §1396d(a). Without a creative and beneficiary-oriented reading of these two provisions together, potential QMBs face an absurd Catch-22. To get the state to pay their Medicare Part A premiums, they need to be QMBs. To be QMBs, they need to have Medicare Part A. Since the Part A premium is currently \$192 per month, low income people cannot afford to undertake liability to pay it.

In a final Medicare regulation that became effective in September 1991, HCFA adopted the approach that QMB status and Part A enrollment are deemed to be conferred simultaneously to avoid the cruel and bizarre Catch 22. HCFA also devised a simple application for "conditional enrollment" in Medicare Part A whereby the individual indicated an interest in being enrolled in Part A with the understanding that it was conditioned on QMB eligibility. Although the September regulation is currently in effect, General Counsel is now proposing to abandon the "simultaneous buy-in" theory in a proposed Medicaid regulation. General Counsel has raised the question of who will pay for the first month Part A premium, since the law says federal money is available under Medicaid the month after eligibility is determined.

General Counsel appears to be raising unnecessary roadblocks to effective outreach by the agency, where the agency's interpretation of the statute is certainly consistent with Congressional intent that all low income individuals have their Medicare cost-sharing paid for by the state. However, to the extent that Congress views these barriers as insurmountable, an easy legislative solution is available. The law could be amended to required QMB coverage effective immediately upon determination of eligibility (or preferably, with three months of retroactive coverage as is available to all other Medicaid beneficiaries) and to require that SSA and HCFA add the QMB identifier to all individuals for whom states are paying Part B premiums. Amendments should make clear that an individual need not incur liability for the Part A premium before her or his QMB eligibility is determined.

The third group identified in the HCFA memorandum consists of Medicaid beneficiaries who are entitled to Medicare Part A for free and for whom the states are already paying the Part B premiums. HCFA states that there are 3.2 million such people, of whom the vast majority are SSI recipients, and of whom only 845,000 have

been identified as QMBs. Nearly all of these 3.2 million people are likely to be eligible to have Medicaid pay for full Medicare cost-sharing.

This is important for several reasons. First, the individual will be relieved of responsibility for the \$100 annual Part B deductible. And, with the state paying the 20% coinsurance (and therefore the provider receiving 100% of the Medicare rate instead of the often lower Medicaid rate), the beneficiary may have greater access to Part B providers, especially physicians.³ It can also mean, for those needing nursing facility services, greater access to skilled rehabilitative services, as discussed above, if the state pays the significant cost-sharing after the 20th day (currently \$81.50).

HCFA proposed inserting the QMB identifier for each of these people and informing the states of their QMB status. It is not clear what General Counsel's response is to this proposal. Your subcommittees may wish to inquire about the status of this.

General Counsel stated in the memo that it could not force states to enroll QMBs; it could only take compliance action against them for being out of compliance with state plan requirements. However, faced with HCFA's evidence of millions of potential QMBs not having benefits, General Counsel does not even propose any compliance action against any state. HCFA has no history of taking compliance action against state Medicaid programs. It is, in fact, an unworkable remedy that does not help poor people needing health care. The Office of Medicaid Management proposed a viable, beneficiary-oriented solution to part of the QMB problem; General Counsel's response is completely disingenuous and unhelpful.

The HCFA November 22, 1991 memo refers to information that would be useful to advocates in individual states in getting benefits for their clients. The subcommittees could provide a great service by asking HCFA to provide to them the following information and then making that information available to the public:

1. For each of the 34 states that currently have Part A buy-in agreements, state the number of individuals for whom the state is purchasing the Part B premium but who are not eligible for free Part A.
2. Identify the eighteen states most egregious in not enrolling potential QMBs in Part A.
3. For each of the 16 states without a Part A buy-in agreement, identify the number of individuals HCFA believes would be eligible as QMBs if they had Part A.
4. For each state, identify the number of people who have Part A and for whom the state is paying the Part B premium but who have not been coded as QMBs.
5. Please identify the states that do not pay Medicare cost-sharing at the full 100% Medicare rate.

State Outreach

Tennessee may provide a model for federally-required outreach at the state level. In response to the first Families USA report, "The Secret Benefit," advocates in Tennessee organized a QMB coalition consisting of nearly all organizations that might have an interest in the program. Coalition members include SSA, state Human Services, Medicare Part B carrier, Commission on Aging, state Department of Agriculture, University extension program, Senior service centers, AARP, the Association for the Mentally Ill, Senator Sasser's office, Social Action Group on Aging, MANNA, legal services programs and others. The coalition has recently

undertaken to train people at senior centers to prepare the QMB applications. As noted earlier in this testimony, the state uses a single page application that can be received in the mail and mailed back in to the Medicaid agency. The coalition has recruited a public relations firm to advise it for free. The state Department of Agriculture has begun a pilot to screen for QMB eligibility at commodities distribution sites. Although the coalition is not established as a permanent entity, advocates recognize the need for ongoing outreach. They feel that they have learned a lot from each other in the coalition. Chairman Ford may ask this group to submit testimony for the hearing record describing its work in more detail than I have.

Proposed Congressional Action

Many, perhaps all, of the suggestions included in this testimony can be achieved without legislation. Your subcommittees might first seek commitments from HCFA and SSA on the following points:

1. To provide affirmative antidotes to the incorrect information about QMB eligibility for disabled people.
2. To use in all its descriptive and informative brochures income figures that account for the SSI \$20/month disregard and to delete references to having Medicare Part A in order to be eligible for QMB.
3. To distribute to all SSA offices, and to require states to distribute to all state Medicaid intake offices, clear, simple and accurate information about the QMB program.
4. To provide answers to the questions set forth above about the numbers of individuals identified as potential QMBs in each state.
5. To develop a one page QMB application for use by SSA workers in conjunction with taking SSI applications or for low-income individuals not entitled to SSI.

If HCFA's General Counsel cannot find authority to have the agency enroll millions of people it can already identify as QMB eligible, amend the law to allow HCFA to do so, to provide that QMB coverage begins immediately upon eligibility determination, and to permit individuals not entitled to free Part A to enroll in that program conditioned on becoming a QMB.

Thank you very much for this opportunity to testify before your subcommittees.

Endnotes

1. In at least the following states, Medicaid hospitalization coverage is more limited than Medicare, either by requirements for prior authorization (PA) or by limits on the days of coverage (#): Alabama (#), Alaska (PA), Arizona (PA), Arkansas (#), California (PA), Connecticut (PA), Georgia (PA), Indiana (PA), Iowa (PA), Kentucky (#), Louisiana (#), Massachusetts (PA), Michigan (PA), Mississippi (#), New York (#), Ohio (#), Oklahoma (#), Oregon (#), Texas (#), Virginia (#), Washington (PA), West Virginia (#). 3 Medicare and Medicaid Guide (CCH) ¶ 15,500 et seq. (State Charts) updated to 1992.

2. John F. Fitzgerald, M.D., Patricia S. Moore, B.S., and Robert S. Dittus, M.D., "The Care of Elderly Patients with Hip Fracture - Changes since Implementation of the Prospective Payment System,"

The New England Journal of Medicine, Vol. 319, No. 21, November 24, 1988.

3. Non-eligibility is most likely to occur in Alaska, California, Colorado, Massachusetts, Rhode Island, Vermont, and Wisconsin, each of which includes people in its basic Medicaid program with income above 100% of poverty, the limit for QMB eligibility.

4. The 34 states have "buy-in" agreements with HCFA under Section 1843 of the Social Security Act that provide an easy, efficient system for them to be billed for Medicare premiums. Under the buy-in agreements, states (and therefore beneficiaries) are not bound by enrollment limitations that apply to individuals, nor are they required to pay penalties for late enrollment that apply to individuals. The 16 state without buy-in agreements pay for Medicare premiums through the "group premium payer process." In these states the enrollment limitations and late enrollment penalties do apply.

5. See New York City Health and Hospitals Corporation, et al. v. Perales and Sullivan, Docket No. 91-6123 (2d. Cir., decided February 3, 1992). This case holds that states must pay for QMBs at the Medicare rate, rather than at the often lower Medicaid rate. Thus, for example, if the Medicare rate for a doctor's visit is \$100, Medicare will pay 80% of that, or \$80 and the state must pay the remaining \$20. This is true even if the state Medicaid rate for the same doctor's visit is only \$80 total. According to the Special Report on Physician Payment Under Medicaid by the Physician Payment Review Commission, No. 91-4 (1991), on average, Medicaid pays 62% of the Medicare payment to physicians.



**APPLICATION
FOR
MEDICARE CATASTROPHIC COVERAGE**

(Front)

OFFICIAL USE ONLY
Date Recd. _____ M or U
Date Recd. _____
Date Received _____

	APPLICANT			SPOUSE			NOTES, COMMENTS DOCUMENTATION
	Yes	No		Yes	No		
1. Do you receive Medicaid?							
2. Name (shown on Medicare Card)	First	MI	Last	First	MI	Last	
3. Address - Street, Apt. City, State, Zip Code							
4. Phone Number	() -			() -			
5. Date of Birth / Sex (M or F)							
6. Social Security Number							
7. Medicare Claim Number	()			()			
8. Eff. Date of Part A							
9. Eff. Date of Part B/Premium	Premium \$			Premium \$			
10. Marital Status - (Single, Married, Divorced, Widowed)							Holding out relationship
11. Do you want Catastrophic Coverage	Yes	No		Yes	No		
12. List names, birthdates and incomes of your children in the home under age 18 or under age 21 if a student.	Name of Child	Birthdate	Type of Income	Amount			
	1.			\$			
	2.			\$			
	3.			\$			
	4.			\$			
	5.			\$			
13. ASSETS	Type	Value	Type	Value	Where Located/How Listed		
Bank Accounts, Stocks, Bonds, Real Estate other than homestead, Certificate of Deposit (CD), Livestock, cash value of life insurance, excess vehicle, etc.		\$		\$			
		\$		\$			
		\$		\$			
		\$		\$			
		\$		\$			
		\$		\$			
14. DO YOU OWN HOME	Yes	No		Yes	No		Total Countable \$
15. DO YOU LIVE IN YOUR HOME	Yes	No		Yes	No		Resources Limit \$
16. HEALTH INSURANCE Other Than Medicare	Yes	No		Yes	No		Resources Eligible Yes No
	If yes, please bring policies with you.			If yes, please bring policies with you.			If yes, to insurance attach SS-018
17. INCOME (Send proof of income)	Type	Amount	How Often	Type	Amount	How Often	(Attach Budget Sheet)
Money received by you and your spouse from working, Social Security, VA, Black Lung, Pensions, contributions, interest income, other sources		\$			\$		Total Income \$
		\$			\$		Poverty Standard \$
		\$			\$		Family Size
		\$			\$		Income Eligible Yes No
18. ELIGIBLE	Yes	No		Yes	No		
19. DATE ELIGIBILITY BEGINS							
20. REASON FOR INELIGIBILITY							
STATE FILE # OR CITATION							

21. SIGNATURES OF DEPARTMENT
OF HUMAN SERVICES STAFF

Eligibility Counselor

Field Supervisor

Date

Date

I understand that my eligibility cannot be determined without completing this application. I understand that I may have to have a scheduled interview. (back)

I understand that unless I help determine whether I am eligible, my worker cannot guarantee that my Catastrophic Coverage/Medicaid application will be completed timely.

I understand that if I am determined eligible on the initial application, benefits begin the month following the month my application is approved.

I understand that by accepting medical assistance through the Medicaid program, I hereby assign to the State of Tennessee all third party insurance benefits or other third party sources of medical benefits, except for Medicare, to which I may be entitled. This assignment will continue during my period of eligibility. I understand that this assignment ends when my eligibility for Medicaid benefits terminates. I further agree to cooperate with the Department of Health and Environment and authorize release of information as necessary to insure recovery of these benefits.

I understand that racial or ethnic information is gathered for statistical purposes only.

I understand that if I am not satisfied with the decision made regarding my application, that I may appeal the decision within 90 days of the date I am notified of the decision.

I understand that I must report changes in my income, assets, marital status, address, health insurance and other circumstances that affect my eligibility within 10 days of the change.

****SOCIAL SECURITY NUMBER:**

Federal regulations require that all applicants for Medicaid, must furnish or apply for Social Security Number. Failure by these individuals to furnish or apply for Social Security Number will result in their ineligibility for Medicaid. Social Security numbers will be used in the administration of the Medicaid Program to check the identity of household members, prevent duplicate participation, and to facilitate making mass changes. Social Security numbers also will be used in computer matching and program reviews or audits to make sure your household is eligible for assistance. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the Medicaid Program.

I hereby make oath, under penalty of perjury, that the information provided and the answers given are true and correct to the best of my knowledge, information, and belief.

Signature of Applicant			Date
Witness (if signed with an X)	Date	Witness (if signed with an X)	Date
Signature of Guardian, Authorized Representative or Responsible Party			Date
Signature of Spouse if applying			Date
Witness (if signed with an X)	Date	Witness (if signed with an X)	Date
Signature of Guardian, Authorized Representative or Responsible Party			Date

Chairman JACOBS. We thank the panel for its contribution to the record, and we call the final panel, including Save Our Security Coalition, the very Honorable Arthur S. Flemming, former Secretary of the Department of Health, Education, and Welfare—and what is not generally known—former member of the National Security Council under President Eisenhower, a big part of history here; and William Lawrence Melton, citizen; Maria Foscarinis; the Downtown Cluster of Congregations, Julie Turner; Mental Health Law Project, Joseph Manes; and, finally, the Community Legal Services Inc., and the Zebley Implementation Project of Philadelphia, Mr. Jonathan Stein.

And so, Dr. Flemming, we are pleased to welcome you—honored to welcome you again.

STATEMENT OF HON. ARTHUR S. FLEMMING, COCHAIR, SAVE OUR SECURITY COALITION (FORMER SECRETARY OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE)

Mr. FLEMMING. Mr. Chairman, I appreciate the opportunity to discuss with the members of the three Ways and Means subcommittees this very important issue.

I will skip part of my outline, but ask that it be included in the record.

I admire the present leadership of the Social Security Administration. I admire their emphasis on the outreach function, and I admire the way in which they are enlisting the support of outside groups through the use of special outreach funds. But, on a national basis, they are fighting a losing battle.

They are fighting a losing battle because they are a seriously understaffed agency. As a first step, they need 6,000 positions for all purposes at a cost of approximately \$600 million. The Commissioner of Social Security has already testified before the Social Security Subcommittee of Ways and Means that she needs 5,000 positions and \$500 million to bring down to normal size the unconscionable backlog of 1,400,000 disability cases, which the administration has budgeted for at the end of fiscal year 1993.

This emphasizes that 6,000 additional positions is only the first step, but it is a step which should be taken, and not put off another year. Then at least 5 percent of the total budget should be added to the budget each year and be earmarked for outreach. This would mean that \$69 million and 1,820 positions would be added to the 1992 budget.

I know the arguments that can be made against the earmarking of funds, but unless this is done, outreach always runs the risk of losing out in the competition for operational funds.

It runs that risk because long lines of people seeking services are more visible than unknown numbers of invisible faces who do not apply for the services that the national community provides.

If Medicare and Medicaid are to carry on substantial outreach in order to make sure that beneficiaries know about services that they can receive under the Medicare Beneficiary Act, they should have funds added to their budgets earmarked for outreach. Those funds may be utilized in the SSA local offices.

If the Administration on Aging is to use their network effectively in the interest of calling to the attention of the aged all of these programs, they should have funds added to their budget.

The time has come, if we really mean business in outreach, to earmark additional funds for that purpose, otherwise we will continue, as a national community, to make provisions for services only to find that the persons who oftentimes need them the most do not know that they exist.

Thank you very much. As always, it is a pleasure to appear before you, and I respect and admire your leadership on this very important issue.

[The prepared statement of follows:]

TESTIMONY OF ARTHUR S. FLEMMING
SAVE OUR SECURITY COALITION

I. Introduction

A. I appreciate this opportunity to discuss with the members of three Ways and Means subcommittees this very important issue.

B. The issue is the direct outgrowth of the arbitrary downsizing of the Social Security Administration from approximately 80,000 to 63,000.

II. Body

A. As a result of this downsizing, the present staff has been forced to make choices which have resulted in the neglect of the outreach process.

B. As Chairman of the SSI Modernization Project, I have visited local SSA offices in all ten of the SSA regions and have participated in a number of public hearings throughout the country.

1. I have observed the inability of SSA staff to pay the attention to outreach they once did.

2. I have first-hand knowledge of the disastrous results of the disappearance of field representatives who often included outreach as a part of their duties.

3. I talked with claims representatives who have been urged to undertake outreach duties but who often times are forced to give up this work and give preference to the large number of persons seeking service.

C. I admire the present leadership of the Social Security Administration.

1. I admire their emphasis on the outreach function.

2. I admire the way in which they are enlisting the support of outside groups through the use of special outreach funds.

3. But they are fighting a losing battle.

D. They are fighting a losing battle because they are a seriously understaffed agency.

E. As a first step they need 6000 positions for all purposes at a cost of approximately \$600 million.

1. The Commissioner of Social Security has already testified before the Social Security Subcommittee of Ways and Means that she needs 5000 positions and \$500 million to bring down to normal size the unconscionable backlog of 1,400,000 disability cases which the administration has budgeted for at the end of fiscal year 1993.

2. This emphasizes that 6000 additional positions is only the first step.

3. But it is a step which should be taken and not put off another year.

F. Then at least 5 percent of the total budget should be added to the budget each year and be earmarked for outreach.

1. This would mean that \$69 million and 1820 positions would be added to the 1992 budget.

2. I know the arguments that can be made against the earmarking of funds.

3. But unless this is done outreach always runs the risk of losing out in the competition for operational funds.

4. It runs that risk because long lines of people seeking services are more visible than unknown numbers of invisible faces who do not apply for the services that the national community provides.

G. If Medicare and Medicaid are to carry on substantial outreach in order to make sure that beneficiaries know about the services they can receive under the Medicare Beneficiary Act they should have funds added to their budgets earmarked for outreach.

H. If the Administration on Aging is to use their network effectively in the interest of calling to the attention of the aged all of these programs they should have funds added to their budget earmarked for outreach.

III. Conclusion

A. The time has come, if we really mean business on outreach, to earmark additional funds for that purpose.

B. Otherwise we will continue as a national community to make provisions for services only to find that the persons who oftentimes need them the most do not know that they exist.

Chairman JACOBS. You are very kind, Doctor. Thank you.

Mr. Melton.

Mr. MELTON. Yes, sir.

Ms. TURNER. We are going to wait until——

Chairman JACOBS. Yes, Ms. Turner.

Ms. TURNER. We are going to wait until his attorney, Maria Foscarinis, is present. Mr. Melton is my client. I am the case manager from the Downtown Cluster of Congregations, and I would like to speak prior to him.

Chairman JACOBS. Fine. Go ahead.

Ms. TURNER. OK. Thank you.

**STATEMENT OF JULIE TURNER, OUTREACH COORDINATOR,
HOMELESS SERVICES UNIT, DOWNTOWN CLUSTER OF CONGREGATIONS, WASHINGTON, DC**

Ms. TURNER. My name is Julie Turner, and I am employed by the Downtown Cluster of Congregations in the capacity of outreach coordinator for the Homeless Services Unit.

I have been employed in this capacity since July 17, 1987. The primary responsibilities of my job are the supervision of case management staff, program development, and the provision of direct services to homeless individuals in the District of Columbia.

The Homeless Services Unit was established to assist the growing numbers of the District's homeless with identifying the major impediment to independent living, locating resources which will successfully address that issue, and ultimately developing a continuum of services which would help the client into independent living and foster self sufficiency.

The majority of the homeless individuals requesting direct services from the Homeless Services Unit have severe debilitating mental and physical conditions which prevent them from seeking and maintaining gainful full-time employment. In most cases, our clients' physical and mental conditions deteriorate while waiting for benefits for which they are entitled under the Social Security Act. In some instances, clients have died before receiving their benefits. This testimony will illustrate specific problem areas within the Social Security Administration which prevent disabled individuals from obtaining supplemental security income, Social Security disability income, and other cash benefits offered through the Social Security Administration.

In order to apply for any cash benefit, the applicant must complete a lengthy application process, which includes an initial application, medical report, and vocational report. For clients with severe mental impairments, this application process is virtually impossible. For clients who have lived on the margin most of their lives, obtaining accurate medical documentation determining disability is an impossible task. Poor people in the United States of America have limited access to health care. This perpetuates disabilities and does not provide the Social Security Administration with accurate information which will demonstrate permanent disability. Although the Social Security Administration will attempt to locate pertinent medical information from a variety of public

clinics and hospitals, this procedure may take months, and delays the process even further.

I have personally assisted 72 homeless individuals with securing some type of Social Security benefit over the last 5 years. In every case but one, clients were denied benefits based on their initial claim.

When the claimant is denied benefits, based on the initial claim, the claimant must request a reconsideration. A reconsideration is a review of medical data and new medical information. This process is completed by the Disability Determination Service. If the DDS believes that the medical information is not adequate, then the claimant is referred to a private physician contracted by the Disability Determination Service. Claimants report, and I have personally witnessed, a DDS physician spending approximately 10 minutes with the claimant. It does not take a medical doctor to understand that this usually is not enough time to determine the extent of disability. This is especially true in instances of severe physical disability, where medical testing is necessary. In the 72 cases previously mentioned, only 1 claimant was approved benefits based on his reconsideration.

The third step of pursuing the initial claim is the request for a hearing with an administrative law judge. The hearing provides the client with the opportunity to present his or her case in person, and provide additional medical documentation which will help the judge with rendering a favorable decision. It is in the best interest of the client to seek legal counsel prior to the hearing. The Social Security Administration provides the claimant with a list of legal clinics which will assist the claimant with preparing a case and offer representation at the hearing. These legal clinics charge a nominal fee, or render services free of charge; however, as committed as these attorneys are, they are overwhelmed with a variety of cases and the waiting lists are long, which delays the process. The Homeless Services Unit has access to pro bono legal services for our clients through the Washington Legal Clinic for the Homeless. Volunteer attorneys from private firms donate their legal expertise to ensure homeless disabled clients are able to receive public benefits. Otherwise, justice can be purchased from private firms which specialize in Social Security matters. I am sure you have seen their advertisements on television. These attorneys usually take their fee from the claimant's back payment if benefits are awarded. Eighty percent of the claims submitted to the administrative law judge are approved.

If the administrative law judge denies the claim, then the claimant or the claimant's attorney may file for an appeal. Approximately 80 percent of the claims are denied by the appeals board. When the claimant is denied their appeal, then the client is presented with two choices. He or she can either file suit in Federal court, or begin the process all over again. Meanwhile, the disabled individual remains destitute, often residing in shelters, eating in soup kitchens, and receiving inadequate medical attention. Their physical or mental conditions deteriorate rapidly. In some cases, the client's lack of income, decent housing, and medical attention, results in death while they are waiting to be deemed worthy of receiving \$400 per month.

I would like to add that this whole process, from beginning to end, if the claimant has to follow it through, takes a minimum of 2 years.

Although time restrictions are imposed on claimants in every aspect of the application and appeals process, there are no time restrictions imposed on the Social Security Administration, except at the initial application stage. Cases are flagged as hardship cases, such as homeless individuals or people with AIDS take up to a year to receive a determination regarding their request for reconsideration. An appeal can take up to 5 months, and that is with congressional attention. There are simply no statutory mandated time requirements imposed on the Social Security Administration with regard to offering the claimant a timely decision.

During 1991, the Homeless Services Unit assisted 59 homeless disabled individuals with submitting claims for benefits. To date, none of our clients have received a final decision. The Homeless Services Unit 1991 yearend report reflects 17 individuals were awarded benefits. Those initial claims were placed in 1988 and 1989.

Chairman JACOBS. Ms. Turner, we are almost going double time here. We have a little bit of a problem. Could you pass it over to Mr. Melton?

Ms. TURNER. Sure. I will do that. Go ahead.

Chairman JACOBS. Your statement will be included in the record, did you understand that?

Ms. TURNER. He is going to be covering most of the rest.

Chairman JACOBS. OK. Good.

[The prepared statement follows:]

TESTIMONY OF JULIE TURNER, OUTREACH COORDINATOR
DOWNTOWN CLUSTER OF CONGREGATIONS

I am Employed by the Downtown Cluster of Congregations in the capacity of Outreach Coordinator for the Homeless Services Unit. I have been employed in this capacity since July 17, 1987. The primary responsibilities of my job are the supervision of case management staff, program development, and the provision of direct services to homeless individuals in the District of Columbia.

The Homeless Services Unit was established to assist the growing numbers of the District's homeless with identifying the major impediment to independent living, locating resources which will successfully address that issue, and ultimately develop a continuum of services which will help the client into independent living and foster self sufficiency. The majority of homeless individuals requesting direct services from the Homeless Services Unit have severe debilitating mental and physical conditions which prevent them from seeking and maintaining gainful full time employment. In most cases, our client's physical and mental conditions deteriorate while waiting for benefits for which they are entitled under the Social Security Act of 1974. In some instances clients have died before receiving their benefit. This testimony will illustrate specific problem areas within the Social Security Administration which prevent disabled individuals from obtaining Supplemental Security Income, Social Security Disability Income, and other cash benefits offered through the Social Security Administration.

In order to apply for any cash benefit the applicant must complete a lengthy application process which includes an initial application, medical report, and vocational report. For clients with severe mental impairments this application process is virtually impossible. For clients who have lived on the margin most of their lives, obtaining accurate medical documentation determining disability is an impossible task. Poor people in the United States of America have limited access to health care. This perpetuates disabilities and does not provide the Social Security Administration with accurate information which will demonstrate permanent disability. Although the Social Security Administration will attempt to locate pertinent medical information, from a variety of public clinics and hospitals, this procedure may take months and delays the process even further.

I have personally assisted 72 homeless individuals with securing some type of Social Security benefit over the last 5 years. In every case, but 1, clients were denied benefits based on their initial claim.

When the claimant is denied benefits, based on the initial claim, the claimant must request a reconsideration. A reconsideration is a review of medical data and new medical information. This process is completed by the Disability Determination Service. If the Disability Determination Services believes that the medical information is not adequate, than the claimant is referred to a private physician, contracted by the Disability Determination

Service. Claimants report, and I have personally witnessed, D.D.S. physicians spending approximately 10 minutes with the claimant. It does not take a medical doctor to understand that this is usually not enough time to determine the extent of disability. This is especially true in instances of severe physical disability where medical testing is necessary. In the 72 cases, previously mentioned, only 1 claimant was approved benefits based on the reconsideration.

The third step of pursuing the initial claim in the request for a hearing with an Administrative Law Judge. The hearing provides the client with the opportunity to present his or her case in person and provide additional medical documentation which will help the Judge with rendering a favorable decision. It is in the claimants best interest to seek legal counsel prior to the hearing. The Social Security Administration provides the claimant with a list of legal clinics which will assist the claimant with preparing a case and offer representation at the hearing. These legal clinics charge a nominal fee or render services free of charge; however, as committed as these attorneys are, they are overwhelmed with a variety of cases and the waiting lists are long, which delays the process. The Homeless Services Unit has access to pro bono legal services through the Washington Legal Clinic for the Homeless. Volunteer attorneys, from private firms, donate their legal expertise to ensure homeless disabled clients are able to receive public benefits. Otherwise, justice can be purchased from private firms which specialize in Social Security matters. I am sure you have seen their advertisements on television. These attorneys usually take their fee from the claimants back payment, if benefits are awarded. 80% of the submitted to the Administrative Law Judge are approved.

If the Administrative Law Judge denies the claim than the claimant, or the claimant's attorney, may file for an appeal. Approximately 80% of the claims are denied by the Appeals Board. When the claimant is denied their appeal than two things can occur: the claimant may either file suit in Federal Court, or begin the application process again. The time frame we are looking at far exceeds two years. Meanwhile, the disabled individual remains destitute. Often residing in shelters, eating in soup kitchens, and receiving inadequate medical attention. Their physical or mental conditions deteriorate rapidly. In some cases the client's lack of income, decent housing, and medical attention results in death while they are waiting to be deemed worthy of receiving \$400.00 per month.

Although time restrictions are imposed on claimants in every aspect of application and appeals process, there are no time restrictions imposed on the Social Security Administration, except at the initial application stage. Cases which are flagged as "hardship cases", such as homeless individuals or people with A. I. D. S. take up to a year to receive a determination regarding their request for reconsideration. An appeal can take up to 5 months and that is with congressional attention. There are simply no statutory mandated time requirements imposed on the Social

Security Administration with regard to offering the claimant a timely decision.

During 1991 the Homeless Services Unit assisted 59 homeless disabled individuals with submitting claims for benefits. To date, none of our clients have received a final decision. The Homeless Services Unit 1991 year end report reflects 17 individuals were awarded benefits. Those initial claims were placed in 1988 and 1989. Meanwhile, the clients without an income remain homeless.

In January 1992 I contacted the Subcommittee on Aging to discuss the problems imposed on the disabled by the Social Security Administration. I spoke with an aid. He informed me that the Disability Determination Service should have at least 60,000 employees available to assist with processing claims, nationally; however, they were operating at 30,000 employees. He also stated that Los Angeles County had 17,000 claims pending. Employees from the national office had been sent to the Los Angeles County office to assist with the backlog. I have also been informed that the District of Columbia office has loaned their employees, from the Disability Determination Service, to other offices. This is ludicrous, because this office has been back logged with local claims for years. They have never had the number of employees needed to manage the volume of claims received.

Over the last 5 years the Homeless Services Unit has assisted 72 homeless men and women with obtaining federal benefits. The number of claims submitted, with no results or results pending, far exceed 300. All of those clients assisted with obtaining benefits reside in decent affordable housing solutions. Mentally ill clients were assisted with housing in community based facilities which offer support groups and psychiatric and social services. These clients are learning how to successfully manage their mental illness, participate in sheltered workshops, and a supportive environment 24 hours a day. Clients with physical disabilities reside in subsidized housing. Many have been able to participate in Vocational Rehabilitation programs. Some have entered college. Others have learned to read and write. All of these people have used their benefit to pull themselves up and out of poverty.

Contrary to popular belief, the homeless people do not choose to be homeless anymore than disabled people choose to be disabled. More times than not, the two go hand in hand. An elaborate Social Security system was developed to ensure that all Americans have the right to a decent life. This system was created to offer every American access to an income which would prevent homelessness. This system has become complicated and inaccessible to millions of people. This has become a country of survival of the fittest. The people who can access the system and persevere receive an income, housing, and medical attention. The others remain homeless without ever receiving assistance to meet basic life needs. They live in our parks, live under bridges, and in shelters, never escaping the downward spiral of poverty and

isolation.

For the disabled homeless this type of life can be prevented if the Social Security Administration made the process less complicated, contract physician who are as interested in the client as they are in making a fast buck off the government, and employed the necessary personnel to get the job done. This would definitely increase the number of people receiving benefits. For many, Social Security benefits will be an avenue off the dole. They will be able to obtain housing and enter employment retraining programs, eventually returning to the work force. Others will be able to receive the health care, housing, and live in a supportive environment.

It is a far greater waste of money to create an ineffectual Social Security system, than creating a system which truly benefits the people.

Respectfully submitted,

Julie Turner
Outreach Coordinator
Homeless Services Unit
Downtown Cluster of Congregations
1313 New York Avenue, N.W.
Washington, D.C. 20005

Chairman JACOBS. Mr. Melton, you are recognized. Can we have a green light over here? Good.

**STATEMENT OF WILLIAM LAWRENCE MELTON, SSI APPLICANT
CURRENTLY HOMELESS, WASHINGTON, DC**

Mr. MELTON. Hi. My name is Larry Melton. I am a 46-year-old homeless man. I have been homeless for 5 years, and I live over at 2d and D—Mitch Snyder's old shelter.

I have worked all my life. I worked in Georgia in the textile mills, and then I managed a grocery store for 7 years. After I moved to the District of Columbia, I worked construction and other manual labor jobs. I have always done physical work, but am no longer able to because of my many disabilities. I would work if at all possible. It is degrading for a man not to be able to work.

I was injured in a veteran's hospital. I was honorably discharged after the Vietnam war. As a result of my injuries, I have degenerative disk disease, for which I have already had one spinal fusion. I have hepatitis B, which I received in a transfusion, and I have thoracic outlet syndrome.

The disk disease causes back problems and I am unable to lift anything. My friends do my shopping for me, because I cannot even carry a bag of groceries back without getting a backache.

I also am restricted in how long I can sit, stand, and walk. Although these disabilities keep me from doing any of the jobs I used to do, I still try. On many occasions, I tried to work. However, the back pain and the jaundice from the hepatitis was so severe I was unable to perform many of my responsibilities. I paid into the Social Security system for 20 years. This money was supposed to help me if I became disabled or when I retired. Now I am disabled, and I cannot even access my own money.

I would like to inform you of some of the problems I have experienced when applying for Social Security benefits. I am a walking example of the failure of that agency to the American poor.

I applied for Social Security benefits five separate times on my own. There was no one at the Social Security office to assist me with the applications and consequently I was rejected five separate times. When I came to the District of Columbia, I found a church social worker to assist me in filling out the Social Security claim. Going over the form with her, I realized that there were a lot of questions that I did not understand. You need an advanced degree just to figure out the application.

Another thing that my social worker did that I had not previously done on the applications, she explained all my disabilities in detail. Because of my pride, I had always minimized my problems. I thought that somewhere down the road, when I was applying for jobs, my future employer might see all the things wrong with me and not hire me.

I have been applying for and trying to receive Social Security benefits for the past 14 years. Let me explain what the process is like for a homeless person with a high school degree.

First, you have to fill out a very complicated form. I know people at the shelter who just look at the forms and give up because they cannot figure out what they are supposed to do. In order to apply,

not only must you fill out the application, but you also need to submit documentation of your disabilities. If you are homeless, you do not have any place to store medical documents. It is not as if homeless people have a desk with a drawer that they can put their medical files in.

Since I did not have records, I had to see a doctor to get a disability determination. The only problem is that without any resources, how do you know who to go see? My social worker arranged for me to see a doctor and be evaluated. I could not have found a doctor without her. She has a list of doctors who provide their services free to homeless people. My social worker has provided me with tokens for transportation, otherwise I could not have kept the appointments.

I have been working with my social worker on this claim for the past 2 years. At the end of the first year, I received a letter from SSA informing me that they had terminated my case because I failed to get something in on time. My social worker had kept a copy of this form, and the date on the letter was well within the required limits. My social worker had a meeting with the director of the D.C. SSA office and, as a result, my case was reopened. If I did not have someone working with me on my case, I would have been terminated. I would have been fed up and, frankly, given up.

Throughout the 2 years that we have been working on this case, I have received numerous letters from Social Security requesting further information. I never know what they want. I take all the letters from SSA over to the social worker. She explains the letters to me and we fill them out together. I know that I could not fill out these forms and requests for information alone. I have tried five times.

It seems like the Social Security system is trying to weed people out rather than get deserving people on SSI and SSDI. To say the system is frustrating is a joke. I have been given the runaround like you would not believe. I have been evaluated by many doctors, and SSA is a champion of stall tactics. When they send a request for information, the people applying always have a time limit. Some are 30 days and some are as little as 1 week to respond. But they have no time limit whatsoever to award or deny you. It is really an unfair system, and the people who need the benefits the most are the very ones being repeatedly denied because they do not understand the system.

If I did not have assistance, I would have already been denied. At least with someone's help who understands the system, I have a chance.

Thank you.

Chairman JACOBS. Thank you for your contribution to the record.

Mr. Manes.

Ms. FOSCARINIS. If it is agreeable—

Chairman JACOBS. I am sorry. Did I—oh, Ms. Foscarinis, I am sorry.

Ms. FOSCARINIS. If it is agreeable to the committees, I would—

Chairman JACOBS. Quite agreeable. I apologize.

Ms. FOSCARINIS [continuing]. I would like to follow Mr. Melton's testimony, and I apologize for my lateness in arriving. I was delayed by a court emergency.

Chairman JACOBS. Maybe that was my problem. I have to check my peripheral vision.

STATEMENT OF MARIA FOSCARINIS, DIRECTOR, NATIONAL LAW CENTER ON HOMELESSNESS AND POVERTY

Ms. FOSCARINIS. Mr. Melton is accompanying the National Law Center's testimony. His predicament, which he has just described to you, is a small example of the predicament facing hundreds of thousands of homeless Americans throughout the country today. These are people who are now on the streets and in the shelters, and who are not receiving benefits that they are legally entitled to.

In some cases, as in Mr. Melton's case, they are people who have worked, they are people who have paid into the system, and they are not deriving the benefits of that system in this time of their most dire need.

Their plight makes a mockery of our Nation's most basic promise of social security.

There is a recent national study which reveals that of all homeless people, only 4 percent receive Social Security benefits—SSI benefits. This is an astonishingly low rate. About 25 to 30 percent of the homeless population suffers from mental disability, and therefore would almost certainly be eligible for these benefits. An additional smaller percentage suffers from physical handicap or is elderly.

These statistics are disturbing. They are not surprising. Application for benefits under the Social Security Program is a complex, sometimes Kafka-esque, process. There is a difficult 15-page form. Medical examinations are required. Applicants must respond to numerous written inquiries sent by mail from the Social Security Administration. They must keep appointments with Social Security employees at Social Security offices.

For homeless people, who typically lack transportation, telephones, a place to store documents, these requirements can be insurmountable barriers. For homeless people who are also mentally disabled, they can be virtually impenetrable.

In a December 1989 interview following her appointment, Social Security Commissioner Gwendolyn King stated, "I believe very strongly we need to do more by way of outreach." Two years ago, in testimony before the House Select Committee on Aging, Commissioner King described the SSI application as "more than a little hard. It boggles the mind."

At the hearing, Commissioner King expressed concern about the barriers faced by the homeless. She said, "I found the program to be an absolute maze, a patchwork of information and instructions that confused me." She said, "I despaired about the confusion it was causing the people it was intended to serve * * *. There exists a moral obligation to reach out and help those in need."

She also said, "We will take any and all measures necessary to ensure that SSI benefits are paid to those who should be receiving them."

SSA's actions have fallen far short of this rhetoric. In reality, SSA has appointed liaisons, has created task forces, and has issued a document called "principles of outreach," but it has not imple-

mented a serious national plan of outreach to the homeless. But this is what is needed.

Given the administration's failure, it is particularly critical that Congress take action, and that these committees take action to address this growing need.

We call upon Congress to act quickly and vigorously to ensure that eligible homeless Americans receive the aid they are entitled to and that they desperately need.

Thank you for inviting our testimony. I will be glad to answer questions.

[The prepared statement and attachment follow:]

Testimony of

Maria Foscarinis, Director
National Law Center on Homelessness and Poverty

My name is Maria Foscarinis. I am Director of the National Law Center on Homelessness and Poverty, a not-for-profit legal advocacy group for the homeless poor. Accompanying me is Larry Melton, a disabled homeless man who has unsuccessfully attempted to apply for social security benefits on five occasions and now lives in a shelter here in the nation's capitol.

Hundreds of thousand of homeless people, now on the streets or in the shelters, are not receiving social security benefits to which they are legally entitled. In some cases, they are people who have worked -- who have paid into the system -- and yet are abandoned in a time of dire need. Their plight makes a mockery of our society's most basic promise: social security.

According to a recent national study, only 4% of all homeless people receive Supplemental Security Income ("SSI") benefits.¹ This is an astonishingly poor participation rate: About 25-30% of all homeless people suffer from mental disability and are almost certainly eligible. An additional 5% (or more) are likely eligible based on age or physical disability.²

Research conducted under the auspices of the National Institute for Mental Health provides additional, city-specific evidence of the exclusion of homeless Americans from the system:³

¹Burt, Martha, Over the Edge: The Growth of Homelessness in the 1980's, The Urban Institute, 1992, p. 20.

²Wright, James D. Address Unknown: The Homeless in America, Walter De Gruyter, Inc., New York, 1989, pp. 62, 65.

³Tessler and Dennis, A Synthesis of NIMH-Funded Research Concerning Persons who are Homeless and Mentally-Ill, 1989.

- A 1985 Boston study found that only 21% of mentally disabled homeless person received any kind of government benefits, including SSI.
- A 1985 Milwaukee study found that only 13% of mentally disabled homeless persons received SSI benefits.
- A 1986 Los Angeles study found that, although about 30% of the homeless population suffered from mental illness, fewer than 9% of the population received SSI benefits.
- A 1986 Detroit study found that only 30% of mentally-ill homeless persons admitted to a state psychiatric hospital were receiving SSI benefits.

These statistics, while disturbing, are not surprising. Application for benefits under the social security program requires completion of a 15-page form. In addition, medical examinations are required for persons claiming a disability. Even if benefits are successfully obtained, maintaining those benefits require ongoing compliance with additional requirements, including responses to written inquiries -- sent by mail -- from SSA and appointments with SSA employees at SSA offices.

For homeless people, particularly those suffering from mental disability, these requirements often present insurmountable barriers:

- Homeless applicants may be unable to afford transportation to the SSA office to obtain an application form, to telephone for a medical appointment, or pay for the travel to a doctor's office or clinic.
- Illiterate homeless applicants may be unable to read the application form.
- Mentally ill homeless persons may be unable to comprehend or respond to the information requested in the forms.
- All homeless persons -- living in shelters or on the streets -- may be unable to collect the required supporting documentation.

The Social Security Administration has repeatedly recognized the need for outreach. In a December 1989 interview following her appointment, Commissioner Gwendolyn King stated: "I believe very strongly we need to do more by the way of outreach."⁴ Two years ago, in testimony before the House Select Committee on Aging, Commissioner King described the SSI application as "...more than a little hard -- it boggles the mind."⁵ At the hearing, Commissioner King expressed concern "about the barriers faced by the homeless," stating:

- "I found that program [SSI] to be an absolute maze, a patchwork of information and instructions that confused me."⁶
- "...I despaired about the confusion it was causing the people it was intended to serve."⁷
- "...there exists a moral obligation to reach out and help those in need."⁸
- "...we will take any and all measures necessary to ensure that SSI benefits are paid to those who should be receiving them."⁹

⁴Tolchin, Martin, "Social Security Chief Seeks to Expand a U.S. Welfare Program," New York Times, December 29, 1989.

⁵Outreach in the Supplemental Security Income Program: Are the Needy Being Informed? Hearing, Select Committee on Aging, U.S. House of Representatives, April 5, 1990, p. 78. Hereinafter Select Committee on Aging.

⁶Ibid., p. 62.

⁷Ibid.

⁸Ibid., p. 61.

⁹Ibid., p. 75.

Nevertheless, SSA's actions have fallen far short of its rhetoric. In reality, SSA has resisted all efforts to establish a national plan of outreach to the homeless. Following a congressional appropriation for FY 1990, SSA awarded two grants to private groups in Chicago and Washington to conduct outreach specifically to homeless people. SSA did not even include funding for the outreach grants in any of its budget request from FY 1991 to 1993.

While SSA claims to have taken steps to implement an outreach program, in reality its effort consists of appointing "liaisons" and task forces. While individual SSA employees have taken it upon themselves to help, SSA has issued only a recommended list of outreach "principles," most of which pass SSA's job on to others. But lists of principles and individual actions do not constitute a serious, national outreach effort by SSA. Yet that is what is needed.

Previously introduced legislation -- the Homeless Outreach Act -- would meet this need by structuring a national plan of outreach to the homeless. Designed to be flexible, the plan would help homeless people through each step of the application process; it would also help homeless people use SSI benefits to secure housing. Ultimately, it is a plan to help elderly and disabled people out of homelessness.

But past efforts to pass the Homeless Outreach Act have been stymied by a cost analysis by the Congressional Budget Office that includes not only the cost of outreach, but the cost of benefits

as well. Because these are benefits to which beneficiaries are already entitled, they should not be included in congressional consideration of the legislation. Alternatively, legislation should be crafted to avoid this method of cost analysis. Above all, Congress should act quickly and vigorously to ensure that eligible homeless Americans receive the aid they so desperately need.

Thank you for inviting our testimony. Mr. Melton will now describe his own experience in seeking help from the Social Security Administration.

Chairman JACOBS. Thank you, Ms. Foscarinis.
Now, Mr. Manes.

**STATEMENT OF JOSEPH MANES, DIRECTOR OF FEDERAL
RELATIONS, MENTAL HEALTH LAW PROJECT**

Mr. MANES. Thank you, Mr. Chairman.

Following on Ms. Foscarinis' testimony, I was somewhat discouraged to hear Mr. Enoff testify that he was not familiar with the New York City outreach project which has been in place for almost 10 years, and has been publicized by the Social Security Administration as a major success. It consists of outreach workers from the DDS office, and the New York State Health Department, as well as claims representatives from the Social Security office, visiting shelters and taking applications, doing preliminary medical examinations, and setting up medical appointments from whom they take applications.

With homeless people, the need is much more than for a set of posters and pamphlets telling them that benefits are available. As you heard from Mr. Melton, they need hands-on assistance from the agency, or others—and the agency is the one responsible—to help them overcome the barriers that SSA through its complicated system, has created for people.

SSA has not issued any national policy statements that outreach to homeless is a priority of the agency. It has not issued instructions to offices to engage in outreach. It has not made outreach a part of the evaluation process for the employees of the agency. It has not created a budget for outreach. These are the things that demonstrate whether an agency is serious about the outreach function.

Outreach for homeless people has been intermittent, partial and at the local option of field office managers.

For children, the SSA outreach has consisted almost entirely of a response to the Supreme Court decision in *Zebly*. Since February 1990, there has been a significant increase in the number of applicants and the number of children who have become eligible for SSI, but it is almost entirely because of the fallout from the *Zebly* publicity.

There has been virtually no other generic type of outreach to children. The *Zebly* outreach is time-limited. It will end soon, and we can expect that, with it, the number of applications and eligibles will also drop.

My organization, the Mental Health Law Project, has just initiated a 2-year effort, funded by private foundations, to reach out to children who are eligible for SSI. We will try to do the things that SSA is not doing but, obviously, the resources that we will have will be much more limited than theirs. We will try to find children in the places where they are. They are in schools, they are in day care programs. They are in other service centers. These are the places where we will try to go to find the children who are eligible and encourage their parents to get them on the program.

If SSA will not do the job alone, without outside assistance, then Congress should mandate that SSA establish a budget, set aside funds for outreach, create an office of outreach coordination in the

Commissioner's office, with authority to make grants and issue instructions to the field offices.

It is unfortunate SSA will not do it on its own, but if it will not, we ask Congress to do it.

Thank you.

[The prepared statement follows:]

TESTIMONY ON SSA OUTREACH TO THE WAYS & MEANS COMMITTEE,
PRESENTED BY JOSEPH MANES, DIRECTOR OF FEDERAL RELATIONS,
MENTAL HEALTH LAW PROJECT
MARCH 26, 1992

Thank you, Mr Chairman, for inviting the Mental Health Law Project to testify this morning. MHLP is a 20-year old legal advocacy organization whose purpose it is to protect the rights of and generate services for people who have mental disabilities.

For the past several years, we actively organized outreach efforts to families with children who are potentially eligible for SSI benefits. We recently completed an outreach project, financed by an SSA demonstration grant, testing approaches to finding and referring to SSA infants and toddlers under age three who are experiencing significant developmental delays. Currently we--together with four other child advocacy organizations--are organizing a two-year national campaign to find and enroll children who qualify for SSI. The campaign is privately funded by the Robert Wood Johnson Foundation, the Nathan Cummings Foundation, the Annie E. Casey Foundation and the Pew Charitable Trust.

We have also pursued legislation to require SSA to undertake consistent and coherent outreach to adults who are disabled and homeless.

My testimony will address SSA's outreach efforts to these two population groups--children and homeless adults. It is not my intention to be overly critical of SSA. The agency has the most client-sensitive leadership we have seen probably since the days of Bob Ball. I also recognize that the agency has serious problems caused by the staffing and appropriation cutbacks in the 1980s. In other testimony, we have urged this Committee and the Appropriations Committee to correct the staffing and funding shortfalls. However, we must challenge SSA's claims that it is doing an effective job of reaching out to children and homeless people.

- o SSA's principal effort to find children is the result of the Supreme Court decision in *Zebley v Sullivan* which held that SSA had illegally denied children benefits that were due them since 1974. It is doing little other outreach than what is required by the court order.

- o SSA's efforts to reach homeless people is now and has always been uncoordinated, intermittent and principally at the option of local managers. SSA has never issued a policy statement that outreach to homeless people is a priority of the agency.

This is our charge. I will attempt to add specifics to the charge and suggest several legislative corrections.

Outreach to Children with Disabilities

While children with disabilities have been eligible for SSI payments since 1974, the program has been a deep secret to most parents. It was only with the Supreme Court decision in *Zebley v Sullivan* in February, 1990 that the public became aware of the benefit. Since *Zebley* there has been a rapid growth in applications and the number of children receiving SSI payments. As of December, 1991, just under 439,000 children received monthly benefits. This is a growth of 48% (+142,556 children) over the enrollment level in December 1989, two months before *Zebley*. We believe that a large proportion of the "new" recipients are *Zebley* class members, rejected in the past, who have applied again and were found eligible under the new disability standard required by the Supreme Court. SSA is also

reviewing their eligibility for retroactive benefits for the period they were improperly denied.

Number of Children Receiving SSI Payments

As of:	Children on Rolls	Increase over Prior Year
December 1987	288,725	
December 1988	290,256	+1,531 +.05%
December 1989	296,298	+6,042 + 2%
February 20, 1990 - Zebley v Sullivan Decision		
December 1990	340,230	+43,932 +15%
December 1991	438,854	+98,624 +29%

However, even with the recent increase in eligible children, we estimate that almost 60% of all children with serious disabilities in low income families who should get SSI cash benefits are not getting them--making their already difficult lives even more restricted. I've attached a table to my testimony containing a state-by-state estimate of over 600,000 children who are eligible for, but are not receiving SSI benefits.

In 1989, the Ways and Means Committee recognized the gap between the number of children on the rolls and those potentially eligible. In OBRA '89, Congress mandated that SSA engage in "ongoing" outreach to children.¹

Unfortunately, SSA appears not to have taken the Congressional outreach mandate seriously. While Commissioner King has publicly said that "the well-being of America's most vulnerable children is an extremely high priority" for SSA,² except for outreach to Zebley class members, the agency has focused little attention on children's outreach. SSA is a hierarchical organization. It operates through instructions and directives to its 1300 field offices and 51 Disability Determination Services. They seldom do what they are not instructed to do. On children's outreach, no policy statements have been issued; no instructions have been given to field offices to begin working with child-focused public and private agencies; no budget for outreach has been established. Outreach efforts are not a part of the field office personnel evaluation process. As best we can tell, the "ongoing program of outreach" required by law has resulted in publication of a few pamphlets and posters and the designation of a coordinator in each Region, but not much more.

¹ Pub. L. No. 101-239, Omnibus Budget Reconciliation Act of 1989, §8008 creating §1635 (42 U.S.C. 1383d), which reads:

a. Establishment. - The Secretary shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.

b. Requirements. - Under this program, the Secretary shall--
(1) aim outreach efforts at populations for whom such efforts would be most effective; and

(2) work in cooperation with other Federal, State, and private agencies, and non-profit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.

² Address to the National Academy on Social Security conference entitled, "How Does Social Security Protect America's Children," January 30, 1992.

The House and Senate appropriations committees, also, have been sensitive to the need for outreach. Although the Administration did not request funds, Congress added \$3 million for SSI outreach activities in FY 1990. Another \$6 million was appropriated in 1991 and \$6 million more in 1992. Congress has appropriated \$15 million for outreach over the past three years. In 1990, SSA awarded 25 contracts to public and private organizations to test various approaches to doing outreach successfully. Three of the projects were aimed at children. The bulk of the awards were to do outreach to elderly people and individuals with disabilities. (Two were focused on homeless people). In FY 1991, SSA made 8 additional awards--none for children. The rest of the \$6 million appropriation for outreach in FY 1991 was used for other administrative purposes. So far in FY 1992, SSA has received over 450 proposals in response to an RFP published last September, but does not expect to make awards until mid-year or early fall, 1992--and it intends to commit only \$4 million of the \$6 million appropriated. SSA's FY 1993 budget requests no funds to continue the demonstrations. Through FY 1992, SSA will obligate about half the money appropriated for outreach.

We consider this a sorry record that casts serious doubt on SSA's commitment to outreach even when Congress has specifically mandated the function and has appropriated funds specifically earmarked for the activity.

SSA's effort to find Zebbley class members is the one bright spot in SSA's children's outreach activities. Here's an example of what SSA is capable of when its attention and resources are focused on a problem. Since July, 1991 when the effort began in earnest, SSA has identified over 200,000 of the 450,000 children illegally denied SSI benefits. SSA supplemented letters to class member's last known mailing address with heavy doses of publicity. The agency has worked closely with state agencies and national disability organizations. And overall has done a good job. But the Zebbley outreach is time limited. Once SSA has completed all that is required by the court order, outreach will cease. We are all fearful that outreach to children other than class members will cease also.

Outreach to People who are Homeless

SSI and SSDI benefits are a vital source of assistance to people who are homeless and also disabled. Not only do the programs provide income to pay rent, buy food and clothing, they are also virtually the only route by which adults who are not part of a family can obtain health services through Medicaid or Medicare.

Yet community surveys reveal that significant percentages of homeless people with disabilities do not receive SSI benefits. CBO has estimated that almost 250,000 homeless people, eligible for SSI and SSDI, do not receive those benefits.³

SSA claims in testimony and public statements that it has "developed an SSA-wide, proactive strategy to reach more potentially eligible individuals" who are homeless.⁴ As evidence, SSA cites the appointment of homeless coordinators in SSA district offices to work with local service and advocacy groups. In addition, SSA claims representatives from some local

³ Memorandum from Patrick Purcell of CBO to Deborah Colton, staff director of the Subcommittee on Human Resources, May 7, 1990.

⁴ Letter from Commissioner King to Representative Robert Matsui, January 2, 1991.

field offices, at times assisted by disability adjudicators from the state DDS, visit homeless shelters to take applications for benefits. Of the 33 outreach demonstration grants SSA has awarded to date, two are entirely devoted to homeless outreach. (Three others include the homeless population as part of their outreach emphasis). These partial, intermittent and uncoordinated activities do not comprise an agency-wide policy.

Congress has addressed the problems of homeless people in several pieces of legislation. In 1986, Congress eliminated the SSA requirement that an SSI claimant must have a fixed address.⁵ In 1987, to protect people at risk of becoming homeless, Congress required SSA to continue SSI payments for three months to individuals admitted to a medical facility who require the benefit to maintain their residence while they are hospitalized.⁶ In the same legislation, Congress extended the period an resident of a public shelter could receive SSI from 3 months in any 12 month period to 6 months in any 9 month period.⁷

SSA opposed all the Congressional initiatives as unnecessary. It now testifies to their utility and importance.

In 1987, Congress also added a requirement for outreach demonstration projects to homeless people to help them overcome barriers they face in receiving benefits.⁸ SSA ignored the provision claiming that money for the demonstration projects was never appropriated. In February 1990, a federal court ruled in favor of SSA in a law suit brought by the National Law Center on Homelessness and Poverty and others challenging SSA failure to carry out the intent of Congress. The court ruled that Congress was not clear in its intent and therefore SSA was justified in not implementing the law.⁹

What the Ways and Means Committee Should Do

Past attempts to design outreach legislation for Title XVI run up against estimating conventions used by CBO which add to the outreach provisions, the benefit payments and health care costs for people who are found eligible as a result of outreach. The more successful the outreach design, the higher the estimated cost of the legislation and the less likely Congress is to enact it. For example, CBO assigned a five-year price tag of \$1.4 billion to the comprehensive outreach bill Mr. Matsui introduced in 1990, HR 4229. Of the total, the outreach costs were less than \$50 million per year. CBO does not apply the same methodology to

⁵ Pub. L. No. 99-570, Anti-Drug Abuse Act of 1986, §11005, amending §1631(e) of the Social Security Act (42 U.S.C. §1383(e)).

⁶ §1611(e)(1)(E) (42 U.S.C. §1382(e)(1)(E)) modified by Pub. L. No. 100-203, Omnibus Budget Reconciliation Act of 1987, §9115.

⁷ Id. §9113, modifying §1611(e)(1)(D) (42 U.S.C. §1382(e)(1)(D)).

⁸ Id. §9117.

⁹ National Law Center on Homelessness and Poverty v. Department of Health and Human Services, No. 89-3331, (D.D.C. February 1, 1990).

appropriated funds for outreach. There only the money actually appropriated is counted as an expenditure.

However, we believe that with careful construction, the Committee can craft an outreach requirement which can be enacted in this Congress and properly implemented by SSA.

The components would be as follows:

1. State that it is Congressional intention that SSA establish an ongoing program of outreach to potentially eligible individuals as part of all Titles of the Social Security Act it administers.

2. Modify the 1989 OBRA provision requiring an ongoing program of outreach to children to include homeless individuals. We recommend that the content of the outreach be patterned on Mr. Matsui's bill, HR 4229.

3. Require SSA to establish an Office of Outreach Coordination in the Commissioner's office. The Coordinator would be required to issue instructions to all regional and field offices on the manner of undertaking outreach or cooperating with public and private agencies in the outreach effort. The coordination office would be authorized to make grants and contracts with private and public organizations for a wide range of outreach techniques. The office would also serve as a clearinghouse of information on the most successful techniques.

4. Earmark a fixed amount of administrative costs in SSA and SSDI to be used for outreach activities. We recommend a total of \$50 million equally divided between Title II and Title XVI specially designated for outreach activities. We recognize that a mandatory set-aside of funds may take resources away from other essential agency activities. However, we recommend this approach over an authorization of funds for several reasons: First, we consider effective outreach to be so vital it should be accorded a high priority. Second, we believe the appropriations committees will honor the Ways and Means Committee priority by increasing the SSI appropriation and the Title II Limitation on Expenditures by the amounts of the set-asides. The Appropriations Committees have added money for outreach in each of the past three years without a request from the Administration. Third, past history demonstrates SSA has a tendency to ignore authorizations.

We also recommend that Congress address the barriers in law and regulations which make it especially difficult for people who are homeless or at risk of homelessness to receive SSI benefits.

1. Establish a category of presumptive eligibility for individuals who are homeless and who, in the judgement of a qualified mental health professional, have a severe mental illness. The presumption would continue for six months while SSA completes its full eligibility determination.

2. Provide three months SSI payment protection for all hospitalized individuals. Currently, three months payment is authorized only if a physician certifies the hospitalization will last less than three months and the patient demonstrates that the SSI payment is needed to maintain the living arrangement to which he or she will return to after discharge.

3. Pay SSI benefits to individuals in public emergency shelters without any time limit. Currently, individuals in public shelters can get SSI benefits during 6 months of any 9-month period of residency. The change would place residents of public shelters on a par with those in privately operated shelters.

CONCLUSION

We ask you to mandate a consistent, agency-wide, funded effort to reach out to all aged, blind and disabled individuals, particularly those who are homeless or at risk of homelessness. SSA will not establish the policy on its own. Congress must do it.

Thank you for the opportunity to testify.

Over Half of the Eligible Children with Disabilities are Denied SSI Benefits Attachment

States	Estimated Number Children Eligible for SSI*	Number Children Receiving SSI**	Eligible Children Not Getting Benefits; Number Percent
Alabama	27,998	12,119	15,879 56.71%
Alaska	1,690	446	1,244 73.61%
Arizona	14,723	5,365	9,358 63.56%
Arkansas	15,447	8,379	7,068 45.76%
California	121,646	38,547	83,099 68.31%
Colorado	10,539	5,059	5,480 52.00%
Connecticut	6,606	2,821	3,785 57.30%
Delaware	1,931	944	987 51.11%
Dist. of Columbia	3,138	1,292	1,846 58.83%
Florida	46,261	23,515	22,746 49.17%
Georgia	30,653	13,376	17,277 56.36%
Hawaii	3,701	572	3,129 84.54%
Idaho	5,390	1,846	3,544 65.75%
Illinois	58,731	21,178	37,553 63.94%
Indiana	20,838	9,594	11,244 53.96%
Iowa	13,677	4,057	9,620 70.34%
Kansas	7,724	3,202	4,522 58.54%
Kentucky	19,148	9,834	9,314 48.64%
Louisiana	31,377	17,339	14,038 44.74%
Maine	3,862	1,472	2,390 61.89%
Maryland	10,700	5,081	5,619 52.51%
Massachusetts	16,413	8,217	8,196 49.94%
Michigan	45,376	14,780	30,596 67.43%
Minnesota	14,964	4,173	10,791 72.11%
Mississippi	20,677	11,689	8,988 43.47%
Missouri	21,562	9,894	11,668 54.11%
Montana	3,862	1,267	2,595 67.19%
Nebraska	6,919	2,194	4,725 68.29%
Nevada	3,138	1,260	1,878 59.85%
New Hampshire	1,207	734	473 39.19%
New Jersey	23,171	10,506	12,665 54.66%
New Mexico	9,143	3,279	5,864 64.14%
New York	82,948	37,233	45,715 55.11%
North Carolina	23,653	13,457	10,196 43.11%
North Dakota	2,655	716	1,939 73.03%
Ohio	46,744	20,803	25,941 55.50%
Oklahoma	15,125	5,669	9,456 62.52%
Oregon	9,735	3,333	6,402 65.76%
Pennsylvania	41,514	21,407	20,107 48.43%
Rhode Island	3,057	1,320	1,737 56.82%
South Carolina	17,398	7,982	9,416 54.12%
South Dakota	3,460	1,549	1,911 55.23%
Tennessee	23,573	11,686	11,887 50.43%
Texas	86,810	29,718	57,092 65.77%
Utah	6,517	2,243	4,274 65.58%
Vermont	1,770	709	1,061 59.94%
Virginia	16,654	8,492	8,162 49.01%
Washington	15,608	5,693	9,915 63.53%
West Virginia	12,470	4,261	8,209 65.83%
Wisconsin	16,010	9,281	6,729 42.03%
Wyoming	1,850	497	1,353 73.14%
Total	1,050,247	438,853	611,394 58.21%

* In 1992, a family of two parents and one child with a disability can earn up to \$21,504 a year before the child becomes ineligible for benefits. We have used this figure, roughly equal to 185% of poverty for a family of three, to approximate the national pool of income eligible children. Note, however, the income limit for a family with unearned income would be lower while the limits for a family with additional children without disabilities would be higher. Income limits would also be higher in the 23 states that supplement the Federal SSI payment.

The state-by-state distribution is derived by updating 1985 state poverty figures (see Leave No Child Behind: An Opinion Maker's Guide to Children in Election Year 1992, Children's Defense Fund, 1991, p. 72) by the percentage increase in national poverty (see Poverty in the United States: 1990, Current Population Report Series P-60, No. 175, August 1991, Table 6.)

The number used to approximate the eligible number of children with disabilities is 4.1 percent. It is derived from the 1986 National Health Interview Survey (NHIS) which estimated that 3.6 percent of non-institutionalized children under age 18 had "major activity limitations." We adjusted this figure to include children living in non-penal institutions almost all of whom are SSI-eligible.

** December 1991 figures obtained from the Social Security Administration.

Chairman JACOBS. Thank you, Mr. Manes.
Mr. Stein.

STATEMENT OF JONATHAN STEIN, GENERAL COUNSEL, COMMUNITY LEGAL SERVICES OF PHILADELPHIA AND ZEBLEY IMPLEMENTATION PROJECT, PHILADELPHIA, PA

Mr. STEIN. Yes. Good morning.

I am Jonathan Stein, general counsel of Community Legal Services in Philadelphia, and we are the Government funded legal aid office that won the largest class action against Social Security in its history—the *Zebley* decision of the U.S. Supreme Court—a decision which found that for the entire history of the SSI Program, for 16 years, SSA had been illegally administering this program and denying benefits to 600,000 disabled child applicants.

The only coordinated outreach that is going on in this agency is coming—as Joe Manes spoke to—directly out of that decision. There is a court-approved order that specifies particular approaches, including mailings to 452,000 denied children, computer matches to locate these children, and publicity about the case.

One should not let the *Zebley* child outreach and increased enrollments, though, mask the fact that effective coordinated outreach and followup in this agency is a dead letter for eligibles, whether they be children, adults, disabled children, disabled adults, homeless, or elderly poor, many of whom are eligible for SSI but not getting it.

We have learned some lessons from *Zebley*. There needs to be a national outreach mandate, implementing specific outreach policies. Eligible households need to be targeted with understandable information, and there must be followup. Outreach is meaningless unless there is followup assistance.

Finally, there needs to be a liberalization of access barriers—actual substantive policies that really deter people and prevent eligible people from getting benefits.

We have some specific proposals.

The first is—as Joe Manes suggested—to establish a new Office of Outreach in this agency. The many hundreds of thousands of eligible children and adults do not need more piecemeal demonstration projects to reinvent the outreach wheel. Enough of demonstration projects.

Let us get serious about outreach. Let us set up a new office, and let us fund it decently. We suggest an appropriation of \$75 million for that office. And let us have an advisory committee of consumers and advocates to ensure accountability, quality, and input into the outreach that this agency is doing.

We also suggest that since outreach is effective only if it is localized, that SSA involve the State disability agencies—these forgotten State arms of Social Security that most Governors do not even know exist in their State governments. The State disability agencies, that do the evaluation work for Social Security, be utilized and that they, too, have advisory committees that not only can help with outreach plans localized for each State, but also provide needed input to improve how disability is done at the front end where all the problems are.

Our second proposal is to decentralize the application process and fund followthrough assistance. Outreach is more than pamphlets, posters, and PSA's, however well intended and partially successful those efforts may be at Social Security. Unless the application process is opened up, extended to where eligibles are, that is, decentralizing it, and unless followup assistance is provided, any outreach effort for the next 50 years is going to be either a failure or only partially successful.

We suggest you look to two recent developments to build these initiatives on. One is the fact that many States, particularly States that have been more compassionate in caring for people, by providing welfare to poor, disabled people who are waiting the many years to get disability—States like New York or Pennsylvania, and others—have established disability advocacy projects. And, with no encouragement from the Feds—they have done it on their own. These projects are models, in about a dozen States, to show how a helping hand can be provided to the applicant who could otherwise never get through the maze of this bureaucracy.

We also suggest a second model to look to, and that is the recent 1990 OBRA requirement that there be "outstationing" of Medicaid application workers where poor people are—the "disproportionate share hospitals," and the community health centers that the Congress funds—bringing the Medicaid application to the Medicaid applicant.

These two initiatives, the latter that Congress has helped get going, and, the former, that States, on their own, have started, leads to the following suggestions.

We suggest that Congress permit State employees—State workers in welfare departments—to take and process SSI applications. They can even be the Medicaid outstation workers that States are now setting up right now. Have them take both the Medicaid application and the SSI application.

We also suggest that Congress either fund existing disability advocacy projects or provide initiatives to States to have these projects, so that the helping hand that helped William Melton here to get onto SSI be available to everyone in every State in the country.

Unless there is followthrough assistance, unless there are incentives to go beyond current efforts, we will be left with the posters, pamphlets, and PSA's approach which is all that outreach is at SSA these days.

Let me conclude with a couple of remarks.

The current outreach to disabled children is inadequate, although SSA has made some efforts here. Every AFDC household, every household receiving WIC or Head Start benefits, every school in the United States should be getting information on SSI disability for children. They are not because there is no concerted adequately funded national approach.

Mr. Enoff's written statement said 60 school boards have been contacted—60 out of how many tens of thousands school boards in the country that need to be contacted?

The elderly poor in the hundreds of thousands remain out there who are eligible for SSI. This agency knows that there are title II beneficiaries in their own computers who are eligible for SSI. They

have never marketed to these elderly the tie-in between SSI and Medicaid. If many elderly people will not apply for SSI because of the limited dollars they will get—the partial supplement to their title II Social Security—at least tell them about the Medicaid tie-in, which may be enormously more valuable to them.

SSI does nothing to market this tie-in between SSI and Medicaid.

My final point is, the tie-in of SSI and Medicaid is not only a vehicle for concurrent outstationing to receive and process applications, it is also an incentive, as I have said, to motivate elderly and disabled children to apply. But for disabled children who should get Medicaid, there is one policy barrier existing in four States—the so-called section 209(b) States: Minnesota, Connecticut, Missouri, and New Hampshire.

In these four States, a disabled child who gets SSI will not automatically get Medicaid, and that is an inequity that we should not await national health care to remedy. National health care, hopefully not like Godot, is coming, but let us not wait. Let us deal with this inequity in these four States by allowing the severely disabled child who gets SSI also to get Medicaid.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JONATHAN STEIN, GENERAL COUNSEL
COMMUNITY LEGAL SERVICES OF PHILADELPHIA

Thank you, Chairmen Downey, Jacobs and Stark for inviting me to testify. I am Jonathan Stein, General Counsel at Community Legal Services in Philadelphia. We are the federal and state funded legal services office serving low income residents of Philadelphia. We also won the largest class action in Social Security history through the 1990 U.S. Supreme Court decision, Sullivan v. Zebley where the Court held that for the entire 16 year history of the Supplemental Security Income (SSI) disability program for children, the Social Security Administration had been applying illegal, restrictive standards resulting in denials to 600,000 disabled child claimants.

Perhaps the only coordinated, national affirmative outreach SSA is doing has followed this Zebley decision where by court order SSA has sent letters to 452,000 children denied 1980-1990 to advise them of their right to be reviewed under more liberal and, finally, now legal standards (which for first time take into account the age-appropriate, daily functioning and real-life impacts of child's disabilities).

SSA, as part of the court approved Zebley settlement, has been obligated to publicize the case and new standard, help find class members and others eligible who have not previously applied, and to fund a Community Legal Services Zebley Project advice hotline. About 207,000 of 452,000 class members have responded so far; through computer matches state welfare departments are determining more current addresses for SSA to send additional mailings.

A 48% increase in children on SSI from 296,298 in December 1989 (pre-Zebley) to 438,854 in December 1991 has resulted. Another 600,000 to over a million eligible disabled children have yet to be found and enrolled.

One shouldn't let the Zebley child outreach and enrollments mask the fact that effective outreach for others eligible for SSI is virtually dead in the water at SSA. And even for disabled children, we have seen SSA earlier ignoring the 1989 OBRA, Section 1635 outreach mandate for children. Of the 33 local demonstration contracts let by SSA in FY 1990 and 1991 only three went for children. And the Zebley outreach itself is only of a short duration.

We have learned though from Zebley that the most effective outreach comes:

- 1) When there are national mandates setting forth very specific outreach policies;
- 2) When the outreach targets eligible households (here

those denied in the past) and makes understandable the benefits to be obtained (facilitated by our review and editing of all SSA agency letters and outreach materials);

3) When the outreach is combined with a follow-up helping hand such as Legal Services attorneys and staff available to help eligible families through the red tape and bureaucracy; and

4) When outreach is combined with liberalization of access barriers existing amidst SSA's policies and practices (here, the new acceptance of functional evidence from parents, teachers and caregivers to establish child disability eligibility).

The overall failings of SSA's outreach and the limited success of Zebley child disability outreach suggest a number of remedial initiatives from the Congress, and hopefully support from an Administration that has professed a strong interest in finding eligible claimants.

1. Enough Demonstration Projects: Fund a New Office of Outreach with an Advisory Committee

The many hundreds of thousands of eligible elderly, disabled adults and children and homeless don't need more piecemeal demonstration projects to reinvent the outreach wheel. After 20 years of not enrolling all those eligible, SSA should start the third decade of the SSI program with a concerted, national outreach program organized by a new Office of Outreach with the consumer/advocate input of an Advisory Committee to insure quality and accountability. A line item appropriation of \$75 million should insure that the variety of sub-classes of SSI eligibles are reached.

As detailed in Joseph Manes' Mental Health Law Project testimony today, the track record of the demonstration projects has been very slow, and by their nature largely inadequate. Legislation passed by this Committee and in operation for two decades, is a dead letter for great numbers of elderly and disabled Americans. Everyone in this room today knows what is needed to reach people* and to insure they overcome barriers to access to benefits. *

*/ Indeed SSA's latest FY 1992 RFP for outreach proposals lists the barriers - all seemingly not of SSA's creation. Appearing at 56 Fed. Reg. 47877 (Sept. 20, 1991) they are:

- Lack of correct information about the SSI program by the target population and by outside organizations that provide services to these persons,
- Inability to handle one's own financial affairs, which may require another individual to assist in making application and, when an applicant is eligible, to receive the benefits

What is lacking is a systemic approach and priority to be given this role of government. Overcoming access barriers and outreach needs to be valued as importantly as other major functions of administration of a benefit program as those eligible not reached today are generally the most vulnerable intended beneficiaries of this legislation.

An Advisory Committee is also essential as SSA's effort will also clearly involve initiatives with the public to address problems that the public may be best in solving, especially when the problems lie with SSA's own way of doing business. The Zebley experience of cooperation and input with SSA has shown the benefits of informed input from advocates and consumers to design more consumer friendly policies and communications. Rather than leave it to SSA to set up an Advisory Committee, or determine its composition, we ask that Congress require its creation with the majority and chair filled by consumer and advocacy representatives.

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- as a representative payee,
 - English language illiteracy,
 - Limited exposure to traditional communications media,
 - Disabilities which limit mobility and connection with social services organizations,
 - Reluctance to accept/admit disability, as a permanent condition,
 - Fear/stigma associated with disability, such as AIDS/ARC, cancer, mental illness, mental retardation, and substance abuse,
 - Homelessness often coupled with mental illness or drug addiction/alcoholism,
 - Perceived welfare stigma of receiving SSI benefits,
 - Distrust or fear of government bureaucracy,
 - Concern that eligibility will preclude work or future work attempts,
 - Lack of transportation and/or access to a telephone,
 - Lack of understanding about how to contact Social Security field offices,
 - Lack of current connection with social service organizations, and
 - Homebound status due to age or infirmity.

*/ This recommendation also comes from the current experience of SSA finally beginning the process of revising very out-of-date child and adult Listings of Impairments. SSA has created what are in effect Advisory Committees but is calling them "workgroups" to avoid public notice and public access to meetings, and in violation of the federal Advisory Committee Act.

SSA has marginalized or ghettoized the consumer and advocacy communities by having them meet, on short notice, just once, and generally keeping them off these "workgroups" that are doing the policy revisions of the Listings. SSA maintains total control of

Because outreach and barrier elimination must be localized to be effective, we also suggest that in each state Congress require that every state Disability Determination agency, under contract with SSA to do all initial claims evaluations, also have an Advisory Committee to come up with state-wide and localized plans for outreach as they involve the primary state agency that does the claims adjudications. The groups can have SSA Regional Office representation, other state agency participation (e.g. welfare and health depts.), and consumers and advocates. The existence of such Committees in Massachusetts and Pennsylvania have shown their value in opening up the claims process to eligible people and to bringing some welcome sunshine and constructive input on operations generally in the states.

2. Outreach is More Than PR and PSA's: Decentralize the Application Process and Fund Follow Through

It doesn't take years of demonstration projects to teach us the limits of pamphlets, posters and PSA's -- however well-intended and partially successful they may be.

Unless the applications process is opened up and extended to where eligible claimants are elsewhere served, and follow-up assistance is provided to address the many process and substantive policy access barriers, outreach will always be a failure.

If SSA will not readily decentralize applications or outstation its staff in a variety of locations like senior citizen centers, schools, Community Health Centers, homeless and drop-in shelters, MH/MR centers, etc. then some innovative steps need to be ordered by Congress.

Two recent developments suggest a direction for Congress to take. First a number of states, especially ones who have done the most in providing welfare to poor people (e.g. New York, Mass., Penna., Ill.) have established limited Disability Advocacy Projects ("DAP's") to assist welfare recipients to apply for SSI or SSDI, gather medical documentation, and appeal improper denials. The result has been increased applications, increased allowance rates - and some reduced fiscal burdens for state welfare and Medicaid programs. This development - itself worthy of separate congressional hearings - has virtually been unreported yet is so revealing of what is necessary to reach out to and get the most disabled through the SSA system.

The second development that has barely gotten off the ground is the 1990 OBRA provision for "outstationing" Medicaid applications at places other than welfare offices such as

the agency and non-agency experts it consults with and loses the valuable input of outside consumers and advocates in the room where the policies are being discussed and altered.

"disproportionate" share hospitals (serving the poor) and federally funded Community Health Centers ("Federal Qualified Health Centers"), 42 U.S.C. §1396a(a)(55), as added by OBRA 1990, P.L. 101-508. This brings the Medicaid application process to where the great number of eligible but unenrolled claimants are.

Congress should build on these initiatives to provide for "outstationing" of state workers who can take and process SSI applications. Remember, the applications process in SSA district offices is limited only to getting the application filled out and then is sent on to the state Disability Determination agency for work-up. SSA need not have a monopoly on the applications function.

To encourage states to do outstationing and to reward those states now doing the most in providing state welfare to those who SSA and its SSI program should be serving, we suggest that Congress fund Disability Advocacy Projects, existing ones and those to be established, as well as, or in the alternative, permit states, with a funding incentive, to take SSI applications. Giving states this ability and paying them for it, also cuts down on costs and burdens at local SSA offices where current workloads prevent adequate servicing of existing SSI caseloads.

"Outstationing" should exist at service providers where eligible claimants are now served: senior centers, MH/MR and Community Health Centers, WIC, Headstart, and Early Intervention Programs, homeless shelters, etc. There is no reason why one can't through additional training build upon the developing system of outstationed Medicaid workers to have them also take SSI applications.

We suggest the Disability Advocacy Program (DAP) model because its focus is on follow-through and direct assistance through the application and appeals process. Simply put, outreach is meaningless without this component. The thousands, perhaps tens of thousands of "failure to cooperate" disability denials, especially among the mentally ill, for example, are due to the lack of assistance available to the claimant.

The name of the disability game is documentation, documentation and more documentation. SSA's legal formalism of placing the burden of proof on the claimant, insures that countless unassisted claimants will never provide adequate evidence of mental or physical disability, much less be even able to articulate with precision what the claimed "impairment" is.

Unless Congress funds follow-through assistance, or gives states the incentive to support such efforts we will be left with only posters, pamphlets and PSA's-- and hearings like this is 2002.

A Note to the Subcommittee on Health: In drafting a

National Health bill if there are to be special efforts to have an outstation enrollment program, please keep in mind the opportunity to combine enrollment also of low income disabled adults and children onto SSI by these workers. Outstationed enrollment should also be focused with such providers as Community Health Centers where primarily low income people are served.

3. Outreach to Disabled Children

With the Zebley Supreme Court decision we won in 1990, and new policies in place that for the first time implement the intent of Congress set forth in the 1972 passed SSI program for disabled children, we have virtually a new program for physically or mentally impaired children. But SSA's current time-limited and content-limited Zebley outreach campaign is not enough.

Even with SSA's efforts, every AFDC household, WIC or Headstart household, and every school in the United States will not have the information they need to insure that eligible families are enrolled. Heretofore, SSI for disabled children has either been invisible to the entire country or known to be such a restrictive program as to be futile to seek help from. (The 600,000 denials from 1974-1990 under the illegal eligibility criteria are a testament to this inglorious history of maladministration and child neglect.)

There are between 600,000 (Mental Health Law Project's estimate) and 1.3 million (ours based on an earlier study of the University of North Carolina) eligible disabled children in the country not enrolled. SSA's computer has the names and last known address of close to 250,000 children denied 1980-1990 who have not been found who are eligible for Zebley class reviews and who undoubtedly contain great numbers of eligible children -- ones who never appealed their denials, or who like a cystic fibrosis child in Philadelphia, Mississippi appealed and was told that her terminal condition was not disabling enough to get benefits.

There is much more that SSA must do to reach out to and assist these children by thoroughly targeting the host of service agencies from foster care homes to schools to WIC programs with a permanent, concerted outreach and follow-through assistance effort as was outlined above.

4. Outreach to the Elderly

Great numbers of elderly remain eligible for SSI and are not receiving the benefit.

The most obvious and targeted approach is for by Congress to require SSA to reach out to those Title II beneficiaries known by SSA to receive Social Security benefits that might likely make them SSI eligible.

There were problems with limited past efforts to do this.

For one, just sending notices out to people is not enough; its the old poster, pamphlets and PSA's approach, well-intended but intrinsically limiting. There must be a mechanism to follow-up with a personal contact with each household getting the notice to insure full comprehension, to answer misconceptions about SSI, and to have a ready answer to barriers of fear or stigma.

In addition, SSA's past outreach efforts here have never really marketed the SSI tie-in to Medicaid. In about 36 so-called § 1634 states, where perhaps 80% of our population resides, (e.g. New York, California, Pennsylvania, New Jersey, Michigan, Massachusetts, Florida, Texas), \$1 of SSI automatically brings you full Medicaid coverage which will also pay for the Medicare premium. Many elderly who would not go through the SSI paperwork, means testing and reporting to get a small SSI cash supplement may take the step when they see they will get access to Medicaid and not pay the premiums, deductibles, etc.

All SSI outreach to the elderly must focus heavily on Medicaid access and be able to compute the dollars of benefits in health care savings for each elderly person contacted.

Finally, the seniors who are members of minority groups must be approached through the local groups they trust. This must be done on a systematic basis and with sufficient funds to insure access by all minority groups of older people.

5. Children's SSI Disability and Medicaid

The tie-in of SSI and Medicaid is not only a vehicle for concurrent outstationing to receive and process both applications, but also is a key incentive to motivate both elderly and disabled child applicants.

A serious obstacle for children in some so-called §209(b) states is that there is no automatic Medicaid for the disabled child enrolled onto SSI. This is an unjust anachronism of earlier law that cries out for correction now. A disabled child on SSI in Missouri or New Hampshire should have immediate access to the Medicaid that his cousin across the state line in Kansas or Vermont can obtain. We can let a National Health bill come and equalize the health care for children across the nation. But as we await the coming of National Health let us at least equalize access to Medicaid for all disabled children on SSI in the 4 or 5 states where this linkage is unavailable.

Thank you for this invitation and opportunity to testify today. 2

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I wish to acknowledge the valuable input and advice of my colleague Richard Weishaupt, Marilyn Holle of California Protection and Advocacy, Sara Rosenbaum of the George

Chairman JACOBS. Thank you, Mr. Stein. That was a very useful contribution.

Mr. Downey.

Mr. DOWNEY. Mr. Chairman, I have been convinced by this panel that much more needs to be done. I hope that, between our two committees, we might be able to sit down with some of the advocates and draft legislation that will begin to address some of these problems.

My guess is that they are basically preaching to the converted. But we have within our means the ability to focus both subcommittees on the monstrous level of neglect that exists out there. To try to short-circuit the bureaucratic maze that has been erected over the last 12 years to deny people what they are entitled to.

I think that is what it is, quite simply. I mean, it is more a conspiracy, in a way. I do not believe in conspiracies, but if you take a look at all of the road blocks, the systematic dismantling of the Social Security Administration, the lack of staff, the lack of effort, the scattered approach, the frightening indifference to the suffering that appears before the various offices, one can only come to the conclusion that we have no policy, and that no policy means that people who are innocent, who need our help, are left to go begging.

That is unacceptable to me.

Dr. Flemming, we await your SSI modernization project. Can you give us a little advance on what is going to come out of that project? Because we intend to hold hearings on it the minute you are finished.

Can you tell us when sir, first?

Mr. FLEMMING. We are going to finalize our request the last part of April, but as a result of chairing this project for the last 2 years, I am convinced that in SSA we are dealing with a seriously understaffed agency.

I have appeared before Mr. Jacobs a number of times on the disability situation, for example. Here we are confronted with a situation where the administration has the audacity to submit a budget that calls for a backlog of 1.4 million. Now, that backlog has grown—just in a few years—from 4,000 to now it is 800,000, will be close to a million by the end of this year. And they have budgeted for a backlog of 1.4 million.

That is an audacious thing on the part of the administration.

I am convinced on the matters that are pending before these committees today, that on outreach we do need to add to the budget a sum of money and earmark it for outreach. Otherwise, we are going to sit here and talk about outreach and not get any action.

I have suggested a 5-percent addition to the budget that would call for about 1,800 additional positions solely dedicated to outreach. No question in my mind but that within the administration—within the Social Security Administration—there are people who will act in a creative way, if they are provided with the resources.

I think it is absolutely necessary for us to add to the budget and earmark a sum of money for outreach, and then go to work on out-

reach. No question in my mind that outreach has been seriously neglected.

As a result of the downsizing of SSA, there are no, to speak, field representatives now. There used to be, and those field representatives worked on outreach, among other things. But they disappeared.

In connection with a project, I visited all the 10 regional offices. I visited local offices. I spent time with claims people. And field representatives have virtually disappeared as a result of this downsizing.

There is only one way to do it, and that is to lick this downsizing—to provide them with 6,000 additional positions. And, in addition to that, to provide them with additional sums of money earmarked for outreach.

That is the only way that we can deal with this problem. We have got to deal with it in a dramatic way, not in a patchwork, piecemeal fashion, as we have done up to the present time.

Mr. DOWNEY. Dr. Flemming, Commissioner King is someone of great depth, interest, and compassion. She is outstanding.

If it were up to her, she would have made this request long ago.

Mr. FLEMMING. I agree with you. I agree wholeheartedly with you.

But she has to operate under the Budget and Accounting Act.

Mr. DOWNEY. Right.

Mr. FLEMMING. I had to operate under the Budget and Accounting Act, and I know she has to defend the President's existing budget.

The existing budget proposal is totally inadequate. Now, she cannot come here and say that. She is prohibited by law from saying that.

What we have got to do is to recognize that we have a seriously understaffed agency. She has a seriously understaffed agency, and we have got to give her relief. We have got to provide additional funds.

I have been before this committee—the Subcommittee on Social Security—a number of times, saying "Let's start by providing 6,000 additional positions." Move it from 63,000 to 70,000. That is where we should start. There has been an exchange of letters on that subject with the Commissioner. She has indicated that she could use that 6,000 very effectively.

I agree with you completely on your analysis of her and of the leadership that she has been providing. But she is hampered because she must operate under the Budget and Accounting Act. She must operate with OMB, in effect, and only the Congress can provide relief on this.

Mr. DOWNEY. Is that the view shared by the other members of the panel?

Ms. Turner.

Ms. TURNER. I think it is. I think outreach is definitely necessary. I think the points—

Mr. DOWNEY. You will have to move the microphone.

Ms. TURNER. I think that the point that has been brought up about the agency being understaffed is quite accurate.

I contacted the Committee on Aging in early January to find out what specific problem areas there were with getting services for my clients. I was informed by an unidentified aide—I do not know where he got these figures from, but what he told me was that nationally there are supposed to be 60,000 employees working for the Disability Determination Service, which is the area that determines the claim, that reviews the medical record. He said there were 30,000 employees, nationally. They were operating at half.

The other information was that Los Angeles was 17,000 backlogged in cases, and the national office had been pulled in to assist them.

I have also been informed that the Washington, DC, office has lost some of their employees to help other States with their backlog. The problem is that Washington, DC, has been backlogged for years. They cannot manage the volume of cases they have coming in, and yet they are loaning their employees to other States.

I think that that is where the problem is. We need outreach desperately. I am not a Social Security worker, but that is what I am doing. I am not doing social work, I am doing their job.

But I think the other thing is, we can have all the outreach programs in the world. We could have one in every major city across the United States, but until we get more employees within the Social Security Administration to determine cases, all those cases that are flagged as hardship cases are never going to get processed. We are still going to have the problem.

Mr. DOWNEY. Mr. Stein.

Mr. STEIN. Yes, I agree, and I think one aspect of this understaffing needs to be emphasized. It is not only the backlogging, which means delay and people either dying or living in enormous pain during that waiting period, it also means greater denials.

We see that in an understaffed State DDS agency, the way they operate is that they process, or try to process, the same number of disability claims. They are told—you know, with a gun to their heads—"You must process these cases." And the way they do it—and every State has done this historically—when the gun is to their head, they push cases through, and if the medical documentation is not there, they simply deny the claim.

They will deny, and deny, and deny, and tell SSA they have done their caseload when, in fact, they have done a very poor and obviously improper job of processing. They have just pushed cases through.

That is the worst and often least visible part of this understaffing.

Mr. MANES. I think the budget, itself, reflects a plea to Congress to do something about the problem. In the congressional justification material that the Social Security Administration sent up, it identifies this backlog of 1.4 million initial applications that will be on file, on any 1 day. By the end of fiscal year 1993.

Their own statement is that that will mean an average processing time for an applicant of 7 months. That is the average. We know many cases take considerably longer. That does not include time required for appeals. But through the DDS, the initial processing time will be 7 months.

Those are not acceptable numbers, I think, for a society like ours.

Ms. FOSCARINIS. Well, I would just like to add, on the point of Commissioner King's commitment—and she has gone on record acknowledging the need for outreach, but obviously without the funds to put that commitment into practice, nothing will change. Nothing will happen.

I think there is really a need for Congress to take action, and there is also an opportunity, in the form of a Commissioner who has already committed herself publicly, and acknowledged the need publicly. This is a particularly critical and good, opportune time for Congress to take some action.

I agree on the point that we are far beyond the need, now, for demonstration programs. We know what needs to be done. There are successful programs, as Mr. Manes stated, already in operation. The time really is for a national program of outreach.

The final point is that this could really make a critical difference in solving the problem of homelessness. There is a very significant percentage of homeless people who are eligible for these benefits. If they receive them it could really make a big difference.

There are already successful programs operating. There are non-profit housing programs operating here in the District of Columbia and other cities around the country, where recipients of SSI benefits are in permanent housing, and they are using their benefits to pay rent.

The benefits can make a difference between being on the street and being in permanent housing.

Mr. DOWNEY. Ms. Foscarinis and Ms. Turner, can you quantify that last statement? You say, "a significant difference." How many homeless persons do you estimate there are in this country?

Ms. FOSCARINIS. How many homeless in the country? A very conservative estimate is, on any given night, 700,000. Over the course of a year, 1 to 2 million. And these are conservative numbers. Some estimate as many as 3 million.

Mr. DOWNEY. What if we were to eliminate the backlog?

How would we reduce that number of persons who are homeless on any given evening, let us say?

Ms. FOSCARINIS. Well, we would provide benefits to maybe 200,000 homeless people—maybe more, maybe 300,000 people, say 30 to 40 percent of the homeless population could be helped in getting these benefits, and that could make a very big difference.

Mr. DOWNEY. Ms. Turner.

Ms. TURNER. I can only talk about local numbers, because we are a local agency. What I can tell you is that we see about 1,400 homeless individuals a year, who walk through our doors and request services.

About 60 to 70 percent of those clients are disabled. The majority are mentally ill. How we have helped clients is once they receive their benefit, the 72 clients I talked about that successfully obtained benefits are all in housing solutions. They are in decent housing solutions.

The ones who are permanently physically disabled, those clients are—many of them have entered college at UDC, and probably will be able to enter the work force.

The mentally ill clients are residing in community-based facilities. They are attending support groups. They have supervision 24 hours a day. Some of those clients have been able to obtain part-time employment through sheltered workshops.

But none of this can be accomplished unless a person is provided with the first tool, and that is the actual benefit.

We also act as representative payees for our clients, for those people who cannot manage their money, so that we can ensure that their rents are paid, and that they are getting appropriate medical attention, and three meals a day.

Most agencies in this city who are social service agencies do the same thing. We cannot cover the whole city. We can only cover a small part. But I know most social workers are committed to doing that. That is our job. Our job is not to do the job of the Social Security Administration. It is to do social work.

That is what I would like to get back to doing, personally.

Mr. FLEMMING. Mr. Chairman, there are plenty of people in the Social Security Administration who want to deal with homeless problem.

To give one illustration, I visited one place where they want to deal with the homeless problem, and they are dealing with it to a certain extent but, at the same time, they have long lines in the local office, and they are confronted constantly with the question of whether or not they are going to deal with those long lines or deal with the homeless situation.

It is wrong to confront them with that kind of a conflict. That is why we are dealing with a seriously understaffed agency and should do something about it so they are not confronted, day in and day out, with that kind of a conflict.

Mr. STEIN. I would like to add just two points here.

One is that if we want to reach the eligibles, I think we have to deal with some substantive policies such as greatly expanding current eligibility policies, and we have to streamline the front end of the system and make it work more efficiently and more easily to award benefits to eligible claimants.

When Mr. Enoff said that—"Well, we have problems determining who's mentally ill in a shelter,"—I would invite him to actually go to a homeless shelter any place in the country and see whether he would then have any problems, or whether a Social Security doctor who is brought to that shelter, would have problems in making fairly quick judgments of who has very serious mental problems that would qualify for benefits. I mean, the problems are not of the magnitude that Mr. Enoff suggested.

Expanded presumptive eligibility is one tool to quicken and make more efficient the front end of decisionmaking.

The second point goes to eligible disabled children. I would like to just add to Maria's estimate of eligible homeless. The number of eligible, low-income, disabled children who should be getting SSI, is estimated to be between about 600,000 and about 1.3 million.

So there is a very substantial number of eligible kids out there, not only in AFDC families, but also in working-class families, since your income can go up to around \$25,000 and still be eligible for some SSI.

These kids live throughout the country. School teachers and guidance counselors see them; social workers see them; pediatricians and nurses see them. But, despite our *Zebley* case, almost no one knows there is an SSI program for disabled children. It is still virtually an invisible program that is only now, slowly becoming visible.

Mr. MANES. I want just to echo what Jon Stein said about presumptive disability for homeless persons who are mentally ill.

Lou Enoff said that it creates real problems, since the claims representative is not a trained person and cannot make a judgment. But Social Security offices make judgments about people with AIDS. For the last 5 or 6 years, they have been on a presumptive disability arrangement.

At least if individuals come in with evidence of their condition, which can apply to either a person with AIDS or a homeless person with mental impairments, the agency can make a presumptive decision about their disability.

That decision is good for 6 months, during which the agency would do a full evaluation. But for those 6 months, the individual is off the streets and, almost inevitably, will be found disabled.

Mr. DOWNEY. Thank you.

Mr. FLEMMING. We are dealing with a very fundamental issue, here, because there was a day when the people at the State level who make the initial decision were told that the policy was, in case of reasonable doubt, resolve it in favor of the applicant.

Then, in the 1980's, we entered into this business of cutting the disability rolls, they were told—the State people—that the policy is not to resolve reasonable doubts in favor of the applicant, but to resolve them in favor of a curtailed budget—arbitrarily curtailed.

That is the heart of the problem.

Now, that policy is gradually coming back—to resolve doubts in favor of the applicant, under the leadership of Commissioner King. But we are still dealing with the situation that was created in the 1980's, when there was an arbitrary decision—GAO said it was arbitrary—to cut back the staff of SSA.

Let us get rid of that arbitrary decision, and let us make it an adequately staffed agency.

Chairman JACOBS. Dr. Flemming, two points, I think, could be made for the record.

The first is that if 5,000 positions to which you referred were put into the administration's Social Security this year, it would not be an addition. It would be a restoration of less than one-third of the positions that have been eliminated during the 1980's.

Mr. FLEMMING. That is right. That is correct.

Chairman JACOBS. As I understand it, about 17,000—

Mr. FLEMMING. Good point.

Chairman JACOBS [continuing]. Were reduced. I should say, in fairness, that some of those reductions were justified by modernization and automation, and so on.

Mr. FLEMMING. That is right. That is right.

Chairman JACOBS. But not all of them.

As is generally known by people who have studied the subject, the RIF's—the reductions-in-force—stayed right on schedule. The automation fell behind time and time again, and partly because of

the willingness of various successive administrators to abandon what had been advanced and start over again, rather like building nine bridges over the Potomac River and never hooking them all together to get across the river.

That is what happened, as I understand it, with the automation. And that is why there is this disparity.

Mr. FLEMMING. I confirmed that when I was out in the field. You are absolutely right.

Chairman JACOBS. Another point, I think—I said there were two, and maybe it is going to be three.

Another point that I think should be made is that a year or so ago a Member of the other body asserted that the Social Security trust fund was being raided for general government purposes. That missed the mark somewhat. It has always been a requirement that the Social Security surpluses be invested in the most conservative bonds possible, and any financial counselor will tell you that is U.S. bonds—never mind what they do with it when they get the money. But, still, on the theory the Government is the last thing to go down, that is the most reliable investment that can be made.

However—however—when an administration, or anybody else, curtails the appropriation of sufficient funds from the trust fund itself to administer the trust fund obligations merely for the purpose of masking the amount of deficit occasioned by questionable expenditures in the Federal funds budget, that is a shirttail cousin of an actual raid on the Social Security trust funds.

When a person pays his or her Social Security tax, he or she pays for benefits under certain circumstances. In the case of disability, if disability, in fact, occurs. In the case of retirement, if retirement, in fact, occurs—not just the attainment of a certain age, but if retirement, in fact, occurs.

You pay for those benefits, but this is also a cousin of justice delayed is justice denied. In the case of people who die before they ever get the benefits that are coming to them, obviously justice was denied absolutely. God Almighty is the only one who could recompense for that.

So, in order to mask the Federal funds budget on discretionary spending—and we all know the priorities of the last 10 or 12 years, almost—just to mask those deficits, artificially to say that a system that has an income of \$375 billion of its own money—own system, own money, self-financing. Talk about balancing a budget and doing a surplus, the Social Security system is a prime example of doing just that.

And to go into that system and say that the people who have paid the taxes for the benefits can swim but they cannot go near the water for either 3 or 7 months—3 months wait this year, and 7 months next year if this budget were honored—a rather dishonorable request, really—is to deny people what they paid for.

Now, I just want to add one other thing. Mr. Melton, your testimony has been particularly beneficial to our process, because you make the point that some of us have tried to make time and time again.

For 20 years you paid into the Social Security system. You are entitled to the benefits for which you have paid, including the

prompt administration. That is part of the benefit for which you have paid. You are entitled to that.

You are far more entitled to that than some contractor who is selling widgets to the Government, especially if they are not useful to the Federal Government, or if there are, shall we say, overruns on the cost of the widgets.

Your dignity in this system is far, far morally—your claim is far more valid than claims that are honored to other citizens who have prospered by very questionable supplies and questionable compliance with their own contracts.

So, your contribution is useful. I think that the public, generally, ought to understand that we are not talking about the flim-flam, jingoism of taking money from me, out of my pocket, to give to other people. We are talking about an insurance program that should be allowed to mind its own business, without meddling from the Federal funds program.

Dr. Flemming.

Mr. FLEMMING. The issue that you have just discussed is why we vigorously support taking the administrative budget of SSA off the general budget, and I hope that that legislation will pass, because that would help very—

Chairman JACOBS. Actually, Dr. Flemming, it is off the regular budget, but it is the cap under the so-called Gramm-Rudman, or whatever it is, budget agreement. It is the cap—

Mr. FLEMMING. That is right.

Chairman JACOBS [continuing]. That meddles in the Social Security trust fund's business, and handicaps or inhibits its performance of its duties.

It has already performed the duty of raising sufficient funds to administer itself.

Mr. FLEMMING. The money is available.

Chairman JACOBS. It is that artificial cap that we hope can be removed, and I think that we have some encouragement from the Budget Committee already.

Mr. FLEMMING. I think we have.

Chairman JACOBS. But it is shenanigans that—or as they used to say, it is a wrong that needs a right. We are doing the best we can to do that.

Mr. FLEMMING. I hope we can get that bill through.

Chairman JACOBS. Thank you, sir. And thank the panel very much for an usually useful contribution to the record.

This concludes the hearing.

[Whereupon, at 12:06 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY ON
OUTREACH EFFORTS IN THE SUPPLEMENTAL SECURITY
INCOME (SSI) PROGRAM

SUBCOMMITTEES ON SOCIAL SECURITY, HEALTH,
AND HUMAN RESOURCES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

BY

DANIEL ALVAREZ, SR.
COMMISSIONER
DEPARTMENT OF HUMAN SERVICES
CITY OF CHICAGO

MARCH 26, 1992

Mr. Chairman, thank you for the opportunity to offer testimony on the persisting need for greatly expanded outreach to potential SSI clients among the homeless of Chicago.

My name is Daniel Alvarez, Sr. I am the Commissioner of the Chicago Department of Human Services which supports approximately 3600 shelter beds for the more than 25,000 men, women and children who experience homelessness in the course of a year in Chicago.

Homelessness is a result of extreme poverty. We have found that many of the homeless persons in Chicago who might qualify for Supplemental Security Income for the Disabled are unaware of the program or of its applicability to them. There can be no doubt that thousands of Chicagoans would be rescued from homelessness if they received SSI.

This is an especially pressing issue in Illinois at the present time. The State General Assistance program has been transformed into a 9-months-per-year program in the current fiscal year, and will contract further, to 6 months per year, in the fiscal year starting in July, 1992. Perhaps 50,000 Chicagoans will lose their meager but vital monthly \$154 of cash income, for April through June, 1992, and then again for 6 of the next 12 months. SSI outreach is no longer simply a question of SSI's superior benefit levels. It is now a question of finding any income at all for General Assistance clients in 9 of the next 15 months.

Like a number of other states, Illinois is faltering fiscally. It is unwilling to increase its tax burden and unable to discharge its responsibilities unless it does. Its poorest citizens are also its least influential, and they are bearing the brunt of the budget cuts.

We desperately need federal intervention to help us to deal with this crisis. To step up SSI outreach, immediately and on a vast scale, would be a uniquely appropriate and extremely helpful response. It is my earnest hope that your hearing will stimulate this response.

Comments of**Edward M. Dale, Esq.****Director****Legal Assistance to Medicare Patients****872 Main Street, P.O. Box 258****Willimantic, Connecticut 06226****Regarding****House Ways and Means Committee Hearings****on****Outreach Efforts in the Supplemental Security Income and****Qualified Medicare Beneficiary Programs**

Legal Assistance to Medicare Patients (LAMP) is a project of Connecticut Legal Services, Inc. (CLS). Formed in 1977 LAMP is the nation's oldest Medicare advocacy organization. LAMP has provided legal representation to over 17,000 persons denied Medicare, Medicaid and Qualified Medicare Beneficiary (QMB) benefits in Connecticut and our staff frequently provide training and consultations for social services organization and health care providers throughout the nation. These written comments are offered on behalf of the Medicare beneficiaries we represent.

We receive some 3,000 calls per year from the elderly and have contact with several thousand more each year through extensive community outreach efforts. Distressingly large portions of those we see, person who desperately need the health care protection afforded by the QMB program or the increase in income that the QMB program offers, have simply never received any effective information on the program. Many have been misinformed as to the existence, eligibility criteria and benefits of the program.

It has been our experience that the outreach efforts of the United States Department of Health and Human Services (HHS), the Social Security Administration (SSA), the Health Care Financing Administration (HCFA) and the Connecticut Department of Income Maintenance, the state agency that administers the QMB program in our state, have been wholly inadequate. The limited outreach that has been done by these agencies seems designed to ensure confusion and limit the availability of benefits under this program.

The notices sent to Medicare beneficiaries by the federal government have contained incomplete and inaccurate information.

1. The notices listed the minimum national income levels for eligibility without regard to state-by-state variations. For example, in Connecticut up to \$183 per month per household member of unearned income is not counted for purposes of QMB eligibility. Since virtually Medicare beneficiaries receive unearned income—typically Social Security benefits—nearly everyone has income that should be disregarded. Thus, the actual income limit for the vast majority of Medicare beneficiaries is \$1,132 per month for a couple, considerably more than the publicized limit of \$766 per month.

2. The notices failed to indicate how and where to apply for QMB coverage. There was no clue that the program was administered in our state by the Connecticut Department of Income Maintenance.
3. The notices failed to indicate that income limits increase each year, gradually increasing the income levels from 90% to 100% of federal poverty guidelines and increased each year to reflect increases in the poverty rates.
4. The notices fail to adequately explain the asset limits for the program and do not note the assets that are excluded from consideration under federal law and the state Medicaid plans.
5. The notices failed to detail the tremendous benefits afforded by the QMB program. QMB payment of the Medicare Part A hospital deductible and coinsurance costs can amount to over \$25,000 for each hospitalization, but this has never been publicized. The availability of QMB payment of Part A premiums—\$192 per month—for those eligible, but not enrolled in Medicare was never mentioned. Similarly the extent to which QMB benefits duplicate the coverage under private Medicare Supplement Insurance (Medigap) policies was not noted. For many, the ability to cancel Medigap policies with no significant loss of health care protection is the most important feature of the QMB program, saving them \$2,400+ per year in expenses.

The net consequences of these omissions has been low participation rates, about 50% of those eligible according to Families USA. Without corrective action to affirmative encourage enrollment and to counteract previous misinformation, enrollment rates will remain distressingly and low.

The inadequacies of federal outreach have been compounded by the poor administration of the program on the local level. There have been and continue to be many flaws:

1. For the first years of the QMB program local Social Security and Connecticut Department of Income Maintenance (DIM) office staff were not properly trained as to the QMB programs. We have assisted a number of clients who asked for application forms for the program and were told that no such program existed or that only full Medicaid would pay the Medicare premiums. Others were dissuaded from applying due to inaccurate information as to income or assets levels.

2. DIM still has no application form for the QMB program. It requires applicants to complete a lengthy, complicated Medicaid application form. In some instances these applications are processed as Medicaid applications with denials being improperly issued to those eligible for QMB, but with income or assets over the limits for Medicaid.
3. There have been long delays in the processing of QMB applications. For those who are found eligible, there is typically a 6 to 9 month delay before Social Security stops deducting Part B premiums from recipients Social Security checks.
4. We have represented a number of persons who have had QMB benefits improperly terminated based on changes in income. In these instances, DIM has reviewed income eligibility based on Medicaid, rather than QMB, income levels. Equally distressing is the manner in which benefits are terminated: without any formal notice and without affording the recipient the opportunity to contest the termination. The culprit, we are told, is a DIM computer program incapable of distinguishing QMB from Medicaid recipients and unable to issue the constitutionally required due process notice.
5. While DIM has, under threat of litigation, provided some QMB training for local office, the agency has done virtually nothing to publicize or promote the QMB program. They have published no outreach material on the program.
6. Even those who are awarded QMB benefits are not adequately advised as to the procedure for using these benefits. They are not advised to present their QMB card when obtaining medical services. Similarly they are never advised as to the range of benefits afforded by the program nor of the additional savings that could be realized by canceling Medigap policies that largely duplicate QMB benefits. In some cases DIM workers have encouraged QMB beneficiaries to retain expense and unnecessary Medigap policies despite the clear financial strain that this places on beneficiaries.

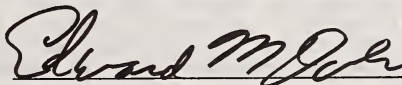
Our organization has done what we can to promote the Qualified Medicare Beneficiary program, but we lack the resources to mount the broad-based outreach effort required to adequately reach the thousands poor elderly who are still unaware of QMB. Our activities have include the publication of a brochure on the program (copy enclosed), distribution of training materials on QMB to the Elder Care Network, press releases and negotiations with DIM to ensure that the program was properly implemented.

We urge the Subcommittee to require HHS, in conjunction with state Medicaid agencies and/or private organizations, to conduct additional outreach. To be most effective, outreach efforts should the components:

1. State-specific informational materials should be developed and distributed to potential QMB beneficiaries that identifies the income and asset levels being used in that state and that clearly indicates income and assets that are not counted. These materials should note the QMB coverage is available to those who are eligible for, but not presently enrolled in Medicare Part A and should stress that QMB benefits general duplicate the coverage afforded by private Medigap policies. This should include targeted mailings to low-income Social Security recipients as well as general outreach using print and electronic media.
2. State administering agencies should be required to publicize the program for potential clients and to provide training on the program for their staff, for social services personnel who work with the elderly and those with disabilities and for health care providers.
3. HHS should monitor state administration of the QMB program much more closely. This should include evaluation of the processing time for applications and for implementation of decisions awarding coverage as well as outreach. Ideally the states should be required to meet specific enrollment goals.
4. The application process should be simplified.

We are delighted that the Subcommittee is investigating this aspect of the QMB program and encourage you to make the changes needed to ensure that critical benefits the QMB program offers are made accessible to low-income Medicare beneficiaries. We hope that the Subcommittee finds these comments helpful. We would be pleased to discuss our comments and suggestions with you or the members or staff of the Subcommittee. Thank you very much.

Respectfully Submitted:



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OUTREACH EFFORTS IN THE QUALIFIED MEDICARE BENEFICIARY PROGRAM

Statement of Elliot P. Legow
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 700 Metropolitan Tower
 Youngstown, Ohio 44503

Last summer I was privileged to testify before a hearing of the Senate Special Committee on Aging on the inadequate outreach efforts in the Qualified Medicare Beneficiary Program. I enclose a copy of my testimony. Since then, I continue to meet low-income clients who are eligible for QMB, but have never heard of it. In response, I have scheduled a number of speeches to seniors to explain the QMB program and how to apply. I continue to hear from individual clients who have had problems securing eligibility and reimbursement for the Medicare premiums that they paid when they should have been covered by the Medicare buy-in program, one of the benefits of being a Qualified Medicare Beneficiary. I have written to Senator Glenn and Senator Pryor regarding continuing concerns with the inadequacy of outreach by the administration regarding QMB. I enclose copies of those letters.

I learned most convincingly just how poor QMB outreach is when I assisted a client this January and February. She had received her initial notice of Medicare enrollment in January 1992 advising her that her Medicare coverage would begin in April. She was mailed a Medicare card, an explanation of reasons why she might not want to enroll in Medicare and a brochure about SSI. The mailing did not advise her that she might be eligible to have the state Medicaid agency pay for her Medicare premiums. It did not mention the QMB program. It did not mention Medicaid.

Of all the possible times to inform a Medicare recipient of her potential eligibility for QMB and the Medicare premium buy-in, the best time is at the time of Medicare enrollment. The Social Security Administration should be required to include a brochure about QMB in the initial Medicare mailing. The brochure must include the current QMB income limit (which is now uniform in all states). It should include a toll-free number for each of the 50 states for an individual to call for a local phone number for the state Medicaid agency at which a QMB application must be taken.

Additionally, the cases of all dually eligible SSI and Social Security recipients should be referred directly by Social Security to the state Medicaid agency at the same time that the Medicare enrollment notice is sent, so the Medicare premium buy-in can be established promptly.

An even better solution to QMB outreach is for the Social Security Administration to be given the legal obligation to

determine QMB eligibility. That would relieve the client from the obligation to learn about the program and to run from agency to agency to secure eligibility. Most QMB eligible persons have never had any connection in their life with the state Medicaid agency, which is frequently the state welfare agency. They would not think that they might be eligible for some benefit through that agency. They may feel some stigma in applying for a benefit through that agency. On the contrary, they are familiar with the Social Security Administration.

There is absolutely no good reason why the Social Security Administration should not be mandated with the responsibility to determine QMB eligibility at the time of Medicare enrollment. Social Security would then notify the state Medicaid agency to pay the Medicare premium and to issue a QMB Medicaid card for the eligible individual.

As I stated earlier, I testified in July 1991 to a Senate Committee hearing about inadequacies of outreach in the QMB program. Now nine months later nothing has improved. The administration has not taken simple and inexpensive steps like printing informative QMB brochures and distributing them routinely at the time of Medicare enrollment and with the annual notice of Social Security benefit amount. It has become clear that the administration has no commitment to publicity of the program. (When I speak to senior citizen groups, I always discover at least one person in each group, often several more, who are eligible for QMB, who have been eligible for months if not years, but never heard of the program.) It is time for Congress to mandate necessary actions by the administration, including QMB eligibility determinations by the Social Security Administration.

Thank you for your attention to this important concern of low-income elderly and disabled persons.

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July 24, 1991

Senator Glenn, other distinguished members of the Special Committee on Aging. Thank you for the invitation to speak to the Committee about difficulties my clients have faced in obtaining eligibility for the Medicare Buy-In program. My testimony is the testimony of my clients as my experience with the Buy-In program has been derived from representing individual clients in Mahoning and Trumbull counties as an attorney with Northeast Ohio Legal Services. I have represented over 20 individuals who had problems or questions regarding their eligibility for status as Qualified Medicare Beneficiaries.

The problems that my clients have encountered are derived from two sources: lack of outreach by the Social Security Administration, resulting in large numbers of persons eligible for the benefits of QMB not knowing about the program and not applying it; and a myriad of procedural problems, generally involving problems in "interfacing" Department of Human Services records with Social Security records. These procedural problems have caused prolonged delays in securing eligibility or have caused loss of continued eligibility for the Buy-In program.

The benefits of the QMB program to a low-income elderly person are threefold: The state Department of Human Services assumes the obligation for the monthly Medicare premium of \$29.90, a figure which by itself represents over 5% of the maximum income of a QMB beneficiary; Medicaid assumes liability for the Medicare part A and part B deductibles and the part B co-payments; and because QMB coverage duplicates the extent of most Medigap insurance policies, the individual in most cases can cancel her private insurance coverage.

Failure to advise low-income persons potentially eligible for the Buy-In program causes them unnecessarily to incur expenses for Medicare premiums, for hospital and physician bills and for private insurance which are a needless drain of their limited incomes. (To be eligible for QMB in Ohio, an elderly or disabled person cannot have countable income of over \$524 a month. In most states the limit is \$552.)

I have attempted to deal with the inadequacies of outreach by the responsible agencies by doing my own outreach in conjunction with agencies that serve senior citizens in Mahoning, Trumbull and Columbiana counties. Modeling a flyer and a poster on one developed by Attorney Janet Pecquet, of Advocates for

Basic Legal Equality, in Findlay, Ohio, I periodically send outreach materials to agencies throughout the area, updating the materials as necessary. (I enclose a copy of version I distributed in recent weeks.) I also send memoranda to advocacy organizations updating them on changes in QMB eligibility standards as well as other medical programs for the elderly. (I enclose a copy of my most recent memorandum.) Seniors in Trumbull County, Ohio, are also very fortunate that the SCOPE senior center has an excellent staff who keep abreast of developments and reach out to clients even in their homes. Many of my cases are the results of referrals from Roseanne Colson-Sobel of clients who she was assisting to enroll in QMB but ran into some bureaucratic roadblock.

[I have received permission from two clients, Ruth Schlaich and Mary Joan Blessing to detail their experiences. Other clients are identified by their initials.]

Some of my own outreach occurs when I interview an older client who calls about some other legal problem and I note his income should make him eligible for QMB but he is not in fact in receipt of that coverage. In those cases I always refer the client to the county Department of Human Services to apply for QMB. The case of my current client Clara P. of Youngstown is instructive as to the failings of outreach by Social Security and of appropriate processing by the Department of Human Services.

Before she turned 65 in April 1989, Mrs. P. was receiving Social Security widow's benefits. She had no medical coverage, but numerous medical problems. Upon her 65th birthday, she was notified by the Social Security Administration of her ability to enroll in Medicare and she did so gladly. Her monthly income (Social Security and pension) was reduced by the \$31.90 Part B premium. Her notice of Medicare eligibility did not tell her that she might be eligible for QMB; it did not refer her to the Department of Human Services to apply for QMB; it did not describe the QMB program.

Mrs. P. was receiving food stamps from the Department of Human Services and reapplied, as required, every 12 months. But none of those applications resulted in QMB eligibility determinations (although the Department of Human Services is required to determine eligibility for all assistance programs).

This year in May, Mrs. P called Northeast Ohio Legal Services because she had been sued by a doctor. I was referred her phone call. When I learned her age, income and resources, I realized she was eligible for QMB coverage and asked her if she was receiving QMB or regular Medicaid. She was receiving neither. So I contacted the county human services department and requested a hearing, contending that her eligibility for QMB should have been established each time over the past two years

ago when she had made an application for assistance. Upon reviewing the case, the county agreed to open Mrs. P's QMB Medicaid case effective July 1989. Mrs. P. now is eligible for reimbursement to her of Medicare Part B premiums she has paid for the past 25 months. I also will assist her to submit the 1989, 1990 and 1991 medical bills for payment to the Ohio Department of Human Services. The amount of her benefit from QMB for these two years will be about \$700 of premiums and hundreds of dollars of medical bills which should no longer be her liability.

Of course these benefits should have been provided to Mrs. P. throughout the past two years and should not have required legal intervention to obtain. I believe that Social Security should have been required at a minimum at the time of her initial eligibility for Medicare to have advised Mrs. P. about the QMB program, its eligibility rules and its benefits and where to make application. This information should be included in the Medicare "enrollment package" and all Medicare enrollment notices. It also should be provided on a separate mailing stuffer that should be mailed to every person in her first month of eligibility for Medicare and annually, perhaps with the notice of the annual adjustment in Social Security benefit amounts.

I have directed many other clients over the past three years to apply for QMB at the county Department of Human Services. For example, when Mrs. H. of Youngstown contacted me in 1989 about a medical coverage issue I advised her that she would become eligible for the buy-in coverage in a year or two as QMB eligibility expansion, mandated by statute, took effect. She checked with me in 1990, and again in 1991. On my advice this January, she applied and was approved. No one else gave her advice about her potential eligibility for the program.

Curious as to what notice Social Security currently provides to Medicare beneficiaries of QMB eligibility, I stopped in at the Youngstown Social Security office last week. I was told that most Medicare pamphlets are sent to providers, so none were on display. But I was given a copy of SSA Publication No. 05-10043. I was shown the reference to Medicaid on page 4 of the Medicare booklet. I read that paragraph and I found it less than illuminating about eligibility criteria and benefits for QMB. The paragraph says, in full:

A Word About Medicaid

Many people think that Medicaid and Medicare are two different names for the same program. But actually, Medicaid is a State-run program designed primarily to help those with low income and little or no resources. Each State has its own rules about who is eligible and what is covered under Medicaid. Some people can qualify for both Medicare and Medicaid. If you would like to know more about

the Medicaid program, contact your local social services or welfare office.

The pamphlet makes no mention of the Buy-In program in the section on Part B premiums nor in the section, What If You Think You Need More Insurance? I believe that Social Security has an obligation to provide a much clearer explanation of QMB to Medicare recipients. The failure to do so explains the low-enrollment rate in QMB.

In describing the second set of problems my clients have had with QMB, I must mention that Ohio is a so-called 209b state, where eligibility for Medicaid is not automatic for all SSI recipients and where, under current law, the Social Security Administration has no role in the Medicaid eligibility determination process. The cases advocates for seniors handle relative to QMB generally relate to processing problems.

Clients' ability to obtain and retain eligibility for the buy-in is compromised by a variety of computer errors and communications problems between county and state departments of human services and the Social Security Administration. Advocates in Ohio have confronted a myriad of such problems, have resolved most of them, but still cannot understand the source of many of our clients' problems with the buy-in. For example, earlier this year, some 8,000 Ohioans who were eligible for buy-in stopped having their Medicare premiums paid by Medicaid. It appeared that this problem was resolved in June when at least some clients received reimbursement checks for as many as four months' premiums that had improperly been deducted. But then two weeks later a Columbus, Ohio, woman again received notice that the premium payment would be deducted from her check in July. Her attorney is attempting to negotiate a resolution of the problem with the Ohio Department of Human Services, but has made known to the state his intention to file a lawsuit if buy-in eligibility cannot be maintained for his client.

That problem seems to involve interfacing between state Department of Human Services computers and computers at Social Security. An Ohio Department of Human Services official told another legal services advocate (whose client was approved for the buy-in two years ago but still is having the Medicare premiums deducted) that the state Department of Human Services is only permitted to contact the Social Security computer one day a month. Other client problems obtaining QMB and buy-in coverage seem to result from computer coding errors at the county human services departments or systems limitations at the state Department of Human Services. I will provide several examples of problems that my clients have encountered:

Ruth Schlaich, age 81, lives in Niles, Ohio. When I first spoke with her in February 1990, her income was \$402 (\$436 gross

including the Medicare premium). She had learned about QMB from Roseanne at SCOPE who had assisted her to apply and she been approved for QMB coverage effective February 1, 1990. The reason for her call to me was to ask my opinion if she should cancel her supplemental insurance coverage. We discussed her Medigap coverage and I recommended she save her \$36.95 monthly premium because QMB coverage would duplicate the supplemental insurance coverage.

Mrs. Schlaich called me again in May 1990 to advise that although she had been receiving her QMB card since February, her Medicare premiums continued to be deducted from her monthly Social Security check. I wrote to the Ohio Department of Human Services about the problem several times. In August Mrs. Schlaich received a refund of her premiums for January-July and finally received a full Social Security check. I think the delay resulted from Mrs. Schlaich having a Medicare number that was different from her Social Security number (because she is a widow and receives Social Security based on her husband's earnings).

I made this assumption because an identical problem occurred to a client Mrs. Penelope S. of Warren in 1989. Her eligibility also took over six months to secure. The delay was due to the Department of Human Services using a Social Security number on the referral to Social Security that did not match the number in Social Security's files. She, too, had a claim number based on her husband's Social Security number.

Mrs. Schlaich's problems with QMB were not over in August 1990, however. She called me again in June 1991 to complain that her QMB card was not being mailed to her every month. Rather it was issued to the county Department of Human Services. She had to call the caseworker each month who would (sooner or later) mail the card to Mrs. Schlaich. As a result she never received the card before the 7th of the month; her May card did not come until May 30. This time I was able to straighten out the problem with two phone calls. The July QMB card was received directly and on time.

Problems like Mrs. Schlaich's and those others described are likely to crop up in the future unless the simplest solution to the problem of QMB eligibility is adopted: namely, transferring the obligation to make eligibility determinations to the Social Security administration.

The need for Social Security to take over the buy-in eligibility process is even more evident for some of the lowest income elderly, who receive both Social Security and Supplemental Security Income (SSI) like my client Mary Joan Blessing. Mrs. Blessing is a disabled 65-year-old resident of Warren, Ohio. She was receiving Social Security and SSI, as well as Medicaid, long before she was 65. When she turned 65 in September 1990, she became eligible for Medicare and Social Security began to deduct

her Medicare premium from her check. Her monthly income was reduced by the amount of the premium.

Social Security should have been aware that Mrs. Blessing was eligible for buy-in coverage without her taking any initiative, simply because she was eligible for SSI. Buy-in eligibility is based on income and resources. The income limit and resource limit are both higher than the corresponding SSI income and resource limits. That Mrs. Blessing was eligible for SSI was sufficient to establish conclusively that she was eligible for the buy-in. There is no reason Social Security should have begun deducting Medicare premiums. Social Security should be mandated to establish a system at Social Security offices in all states for automatic determination of eligibility for the buy-in at least for all persons dually eligible for Social Security and SSI, like Mrs. Blessing.

In the absence of such a simple one-stop system, Mrs. Blessing had to apply through the county Department of Human Services for eligibility for the buy-in. When the Medicare premium deductions continued into December although she had applied in September, Mrs. Blessing was referred to me by her outreach worker. I wrote and called the county and state departments of human services in December and January. On February 21 I received a letter from the county Department of Human Services explaining that, "Ms. Blessing's social security claim number was not written on the (form number) 2151. This matter was corrected . . . " Ms. Blessing advised me on March 25 that she had received a refund of all the premiums erroneously deducted the previous seven months. So, eventually Mrs. Blessing was made whole, but with a monthly income of \$427, she had to sacrifice much more than luxuries while the Medicare premium of \$29.90 was deducted from her income each month.

Betty V. of Niles called me April 2 this year because she had applied for QMB coverage nearly a year before (June 26), had technically been approved (effective July 1, 1990) but her premiums continued to be deducted. I called an official at the Ohio Department of Human Services who had helped resolve one of the earlier cases. She advised me that, once again, a caseworker at the county Department of Human Services had neglected to properly enter data into the computer system. So once again an eligible client had not been able to receive the benefits of QMB. Again the problem was corrected retroactively.

Frances M., age 71, of Hubbard, Ohio, called me earlier this month. She, too, had never heard about QMB until Roseanne from SCOPE Senior Center advised her of its benefits earlier this year. She applied, was approved, received her QMB medical card starting in April, but still premium deductions for Medicare continue. Her case is not yet resolved.

Some of the solutions for the problems my clients have had are obvious. If the goal is to insure that all low-income elderly and disabled persons who are eligible for the QMB program receive the program's benefits, the responsibility for eligibility determinations should be transferred to the Social Security Administration. Social Security already enrolls all Medicare participants and has information on the income of recipients. Social Security can be mandated to determine QMB eligibility for all persons with income below the QMB limit, without the person making a specific request for coverage. Social Security administration of program eligibility would avoid the problems of matching numbers between Department of Human Services and Social Security Administration files that continue to bedevil the current system. Shifting the required initiative for QMB application from the low-income elderly or disabled person to the Social Security office is the best means to secure full program coverage and to secure congressional intent.

At a minimum, Social Security should be required to determine QMB eligibility for those persons dually eligible for both Social Security and SSI.

If, however, the program will continue to require applications by individuals at state human services departments, then Social Security must take a number of steps to expand outreach. Social Security should be required to advise all persons about the QMB program both in writing and orally when they first become eligible for Medicare. QMB Notices should be included in the Medicare "enrollment package" and Medicare enrollment notices. These notices should detail the QMB eligibility criteria, QMB program benefits and advise where to make application. Identical notices should be provided annually, along with the individual's notice of changed Social Security benefits. The Medicare pamphlet should be revised to explain QMB. Social Security should publish and widely disseminate a pamphlet limited to QMB and the Buy-In program.

Thank you again for your invitation to address the Special Committee on Aging. I hope these hearings result in adoption of legislation or of agency procedures to insure that the benefits of the QMB program are secured by all person who are eligible for them.

Sincerely yours,

Northeast Ohio Legal Services

Elliot P. Legow
Attorney at Law

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January 21, 1992

Senator John Glenn
 United States Senate
 Washington, D.C. 20510-3501

Re: My clients Clara Partlow and Mina Henderson
 Qualified Medicare Beneficiary (QMB) program

Dear Senator Glenn:

Last summer I was honored to be invited to testify to the Senate Special Committee on Aging hearing about the inadequacies in publicizing and implementing the Qualified Medicare Beneficiary (QMB) program. I testified to the experiences of a number of my clients. Six months later, the system is working a little better. Many eligible clients still are not being made aware of QMB coverage. The Ohio Department of Human Services has spent some time correcting its systems problems, so delays in effecting eligibility have been reduced.

However, in correcting past failures to correctly process QMB eligibility I have run into a problem that appears to be the result of Social Security Administration policy. On behalf of Clara Partlow (about whom I testified) and Mina Henderson, I secured determinations by the Mahoning County Department of Human Services that QMB eligibility existed retroactive to July 1, 1989, and January 1, 1989, respectively. (Both women were DHS clients whose cases were never reviewed for QMB eligibility prior to my requests in late 1991.) After some additional delays, both women recently advised me that they received refund checks from Social Security.

Neither refund check came with a cover letter explaining the reason for nor the determination of the amount of the check. I was able to compute the time period the refunds were for and discovered in both cases that refunds were made for each month starting October 1989. Mrs. Partlow was not refunded for Medicare premium payments withheld from her Social Security in July, August and September, 1989. Mrs. Henderson was denied reimbursement of premiums withheld in January-September, 1989.

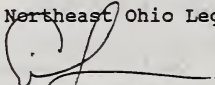
It appears that the Social Security Administration has a policy limiting the refunds of Medicare premium payments. I cannot say how many cases have been identified like those of my two clients who were improperly not placed on the buy-in prior to October 1, 1989. From my experience, I can estimate at least in Ohio that the number of similar cases that exist but have not yet been identified must be fairly high.

I would appreciate your assistance in determining Social Security Administration's policy regarding time limits on refunding wrongfully withheld premiums and further in changing that policy.

Thank you very much for any assistance you can provide to Mrs. Partlow and Mrs. Henderson and other low-income elderly.

Sincerely yours,

Northeast Ohio Legal Services



Elliot P. Legow
Attorney at Law

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February 27, 1992

Senator David Pryor
 Senator John Glenn
 Special Senate Committee on Aging
 Washington, D.C. 20510-6400

Re: Qualified Medicare Beneficiary program

Dear Senator Pryor and Senator Glenn:

Your committee gave me the opportunity to testify last summer about problems with the Qualified Medicare Beneficiary (QMB) program. The identified problems dealt with failure by the Social Security Administration to adequately publicize the QMB program. I also testified about the red tape and confusion my clients have faced in securing eligibility for QMB in Ohio.

I continue to speak to clients about enrollment difficulties and find that publicity is still lacking. I have spoken to numerous senior citizen groups and, although I always meet some seniors who are enrolled in QMB, every meeting turns up at least one person who is eligible but unaware of the program.

I also have many clients who contact me about QMB. I write about the experience of Dorothy Modarelli of Youngstown, who called me after receiving her initial Medicare enrollment notice. Mrs. Modarelli will turn 65 in April. She receives both Social Security disability and SSI. She already receives Medicaid.

She received a mailing from Social Security in January with what appears to be the standard initial Medicare enrollment notices. The packet included three items: a Medicare card, with accompanying cardboard information form; an "Important Message About Your Medicare Protection" (which I enclose); and a folder about SSI.

The "Important Message" explains when and why a person might not want to enroll in Medicare. It says not one word about QMB, nor about Medicaid. It says nothing about "low-income" nor does it advise that many people do not need to pay for their Medicare premiums.

Mrs. Modarelli had to make a few phone calls, to Social Security, to the Department of Human Services, and to me until she realized that, because she already was on Medicaid her Medicare premiums would be paid for her.

However, if Mrs. Modarelli's income were a bit higher and she were not an SSI recipient, the notices sent by Social Security would not have given her any reason to think that she should call the Department of Human Services to enroll in Medicaid. I and other witnesses at last year's hearings concurred that the best time to inform persons about QMB is prior to the initial enrollment in Medicare. It would be very easy for Social Security to rewrite the "Important Message About Medicare" to include a prominent message about QMB.

I am curious what positive results have come from the QMB hearings and the promises made by HCFA and Social Security to improve their outreach efforts. I recall that several pieces of legislation had been introduced to mandate outreach improvements. Has any legislation to that effect been enacted?

Thank you again for your concerns about this issue and your desire to insure that low-income disabled and elderly persons are protected from liability for the high costs of Medicare (and supplemental insurance) and the gaps in Medicare coverage.

Sincerely yours,

Northeast Ohio Legal Services

Elliot P. Legow
Attorney at Law

EPL:el
Enclosure

TESTIMONY OF MARTHA MARSHALL AND CARROLL D. MOORE
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Chairman Jacobs, Chairman Stark, Chairman Downey, and members of the sub-committees:

I am Martha Marshall, President of the National Association of Disability Examiners (NADE). Earlier this month our Association testified before the Sub-Committee on Social Security on the Adequacy of the President's 1993 Budget Request. This hearing is directly related to that issue, and I am pleased to have the opportunity to submit this statement for the record.

There are those who would argue that the Secretary's outreach activities are working too well. In fact, someone has said that a better name for it would be "over reach" initiatives. Initial applications for disability benefits have reached unmanageable levels. Backlogs in the State DDSs have reached approximately 800,000 claims and this number continues to increase. It is projected that the time required for a claimant to obtain a decision on his/her claim may soon exceed seven months! Nearly every state now has "staged" cases - that is cases which have not even been processed into the system. Although there are a number of factors which contribute to this increase in applications, certainly the Secretary's outreach activities is a significant one.

On the other hand, activities initiated at the federal level may not be implemented at the state and local level. Years of "downsizing" combined with increasing workloads have hampered effective implementation of outreach activities. Local district office public relations units have been severely reduced, if not eliminated. The workloads there have also increased. As a result, applicants receive less assistance in processing their claims.

In the DDSs, public relations activities have also been severely curtailed. There is less opportunity to inform claimants and advocacy groups about the disability program and what they can do to help expedite claims. There is less opportunity to educate medical sources and others who are asked to provide information. In light of budget restraints and the need to have as many people as possible involved in actual case processing, these types of outreach activities are, of necessity, considered "luxuries". At the same time, the Secretary's outreach activities are targeted to the very population whose claims are most difficult to process - children, homeless, and HIV infected individuals.

Many of these claimants have few, if any, medical sources. Those who do receive ongoing treatment are often seen in large clinics which are traditionally slow to provide information, or who are not familiar with the Social Security and Supplemental Security Income Disability Programs and do not understand what is needed - or why. Many sources question why they are being contacted to provide information on children. Schools are being asked to provide a great deal more information than they did in the past, and they, too, are not sure what is needed or why. The national initiatives, to be effective, must be accompanied by local and state efforts and this is frequently not possible in the current fiscal and workload environment.

Unfortunately, both the "successes" and the "failures" of SSA's outreach have disadvantaged the applicant. The "successes" have resulted in unmanageably high backlogs and unacceptably long delays in development and adjudication. The "failures" have produced an inability to adequately assist applicants in filing and processing claims which, in turn, contributes to the backlog and processing time crises. Reduced public relations activities further slow development and adjudication because sources are either unaware of these

programs, or do not understand the type of information the DDSs need or the importance of the information they provide.

While the philosophy of outreach activities is commendable, the reality of additional claims, without adequate funding further negatively impacts on the ability of the DDSs to service the clients efficiently or properly. Again, we reiterate the need for the Congress to provide adequate, stable funding if the Disability Program is to operate effectively and accomplish its mission. While contingency funding, such as was offered in 1991, helps in an immediate crisis, it is only a short-term solution, and does not afford the states with long-term funding on which to plan. Our Association appeals to you to take appropriate action to adequately fund this program so that we can offer the quality of service these constituents need and deserve.

COMMENTS SUBMITTED BY THE NATIONAL HEALTH LAW PROGRAM, INC.

Mr. Chairman and members of the committee, we appreciate the opportunity to present written comments for the printed record of the joint hearings of the House Committee on Ways and Means and the Subcommittees on Social Security and Human Resources to identify obstacles that prevent women, children and other individuals with HIV related disabilities from qualifying for social security disability insurance (SSDI) and supplemental security income (SSI).

We, Laurence M. Lavin, Director, Gregg Haifley, Managing Attorney and Dimetria A. Jackson, Staff Attorney, respectfully submit this statement on behalf of the National Health Law Program. The National Health Law Program (NHeLP), is a national nonprofit support center for legal service providers throughout the country. NHeLP focuses on access to health care for low income persons, minorities, the aged and the disabled through research, analysis, publications, trainings, co-counseling litigation and representation of clients in the administrative and legislative process.

While we commend the Social Security Administration (SSA) for reconsidering its current eligibility criteria for disability and HIV infection, we are concerned that the proposed formal regulations, entitled "Immune System" listings, fail to list many impairing conditions and require stringent proof for the four newly added functional tests and conditions. As a result of the proposed regulations some persons who currently meet the CDC definition for AIDS will not be considered disabled according to the SSA.

While SSA may be attempting to develop standards appropriate for disability determinations, the published standards create several obstacles for disabled claimants to meet the requirements. The problem areas include:

1. Impairments omitted from the listing;
2. Listed conditions requiring a high degree of severity;
3. T-cell count requirements that appear arbitrarily set;
4. Functional tests that are inappropriate and difficult to document;
5. Documentation requirements for conditions persistent and/or resistant to therapy which may deprive many low income people from obtaining benefits who do not have access to consistent primary care.

The Secretary acknowledges in the introduction to the listing that women may manifest HIV/AIDS differently than men, but fails to include these conditions within the actual listings. The Secretary notes that adjudicators must carefully scrutinize medical evidence and be alert to the variety of medical conditions specific to women which include, but are not limited to vulvovaginal candidiasis (yeast infections), genital herpes and pelvic inflammatory disease (PID) and notes that these conditions may be more severe and disabling in immunosuppressed women. Also omitted from the listings are: recurrent or refractory pelvic inflammatory disease, recurrent herpes, abscesses of an internal organ or body cavity, chronic genital ulcers, syphilis or neurosyphilis.

SSA's failure to include gynecological conditions within the listing, with the exception of recurrent vaginal candidiasis (in conjunction with another condition listed in Section M(3) and functional impairments) and cervical cancer in advanced stages, creates a burden on women claimants who will be required to meet the equals portion of the "sequential evaluation process" because the majority of gynecological conditions have been omitted from the list. Step three of the process asks whether the claimant has an impairment that meets or equals in severity one of the medical conditions described in the listing of impairments. Women will have to demonstrate that their HIV related gynecological conditions equal the listing by comparing the signs, symptoms and laboratory

findings with corresponding criteria shown in the listing. Since the Secretary recognizes the severity of gynecological conditions by alerting adjudicators of the prevalence of such conditions, the gynecological conditions noted should be included within the actual listings.

To be eligible for benefits a claimant must have cervical cancer in Stage II, which extends beyond the cervix into the vagina or uterus. A more appropriate standard is FIGO Stage IB. While Stage II is a more severe form of cancer, the therapies and disabling nature of the conditions are the same. Therefore, there appears to be no reason to exclude women with Stage IB cervical cancer.

The conditions listed in §14.08M(2) must be persistent or resistant to therapy and require the claimant to meet two of the four functional impairments. For the conditions listed in §14.08M(3) the claimant must have two of the conditions which must persist over a 2-month period. The claimant must also meet two of the four functional tests. HIV-related conditions are the only physical impairments in the SSA adult listings that also require functional restriction tests. Each of these conditions in and of themselves should be considered disabling. Imposition of functional tests creates obstacles to securing disability and imposes burdens on documentation requirements of functional impairments.

The functional test requirements are more difficult to meet than the prior rules, included in Social Security POMS at §§24525.001-24525.035, in which claimants were only required to meet one of two functional tests: a marked restriction of activities of daily living or deficiencies of concentration. The proposed functional impairments described in section 14.08M(4) require a claimant to prove that he/she meets two of the functional tests.

Three of the four functional tests (a) activities of daily living; (c) task completion; and (d) episodes of decompensation set a higher level of functional restriction than is required to establish a finding of disability under the Social Security Act. In order to prove disability, under the Act, a claimant must prove an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or expected to last for 12 months. The proposed functional tests exceed a showing of whether a person with a physical impairment can engage in substantial gainful activity. The fourth functional test, (b) social functioning, is defined as meaning "most of the time the individual is unable to sustain interaction and communication." Persons who are otherwise disabled may still be able to maintain close ties, interacting and communicating with their family and friends. As a result, this test does not effectively evaluate the physical impairments associated with HIV infection.

A continuity of care or treatment rarely available to low income people is necessary to document the requirements of §14.08M(2-3) and the functional tests. The proposed regulations will make it difficult for low income and minority claimants who must rely on city hospitals, clinics and emergency rooms for their primary health care, to properly document their medical conditions. Many clinics are understaffed and overwhelmed, as a result patients often see different physicians and documentation of illness or functional ability is scarce and incomplete.

The listing in Section M(3) proposes a T4-cell count of 200 or below or 14 percent or less lymphocytes. The T4-cell count is arbitrarily applied, absent further documentation from SSA to substantiate the appropriateness of 200 or less lymphocytes for men and women.

SSA provides presumptive disability benefits for a maximum period of six months to claimants awaiting a formal disability determination. Presumptive disability findings are important because they provide the claimant with immediate cash benefits and

in many states a presumptive disability finding for SSI will result in Medicaid eligibility. In the past, SSA has relied upon the CDC definition of AIDS as the principal basis for awarding disability benefits to persons with AIDS. The Committee should carefully scrutinize the deletion of certain opportunistic infections as being presumptively disabling on the basis of diagnosis without additional requirements.

Under the new process the field office will confirm a claimant's disability based on a newly designed physicians report on allegation of HIV infection, in which doctors are required to check the applicable criteria. Section G of the form "Functional Limitations" requires medical personnel to make subjective judgments because the terms "extreme", "marked", "moderate" and "mild" are not defined on the form for purposes of making an accurate and informed evaluation of the claimant's functional limitations. The regulations are not clear in that they do not define the terms "extreme", "moderate" and "mild".

The listings will make it difficult for claimants currently receiving benefits, according to the CDC definition of AIDS, to continue receiving benefits and newly eligible persons to obtain a finding for long term disability as a result of the functional tests and the documentation requirements of the proposed listing.

SSA should revisit all of the aforementioned issues before adopting a final regulation. Without changes, low income persons, women and substance abusers will not be afforded an equal opportunity to qualify for social security disability benefits based on their HIV related disabilities.

Congressman Robert T. Matsui's legislation, the Social Security and AIDS Disability Act of 1991, H.R. 2299 proposes to make disability benefits available to people who are disabled by HIV related conditions. Current and past SSA practices have kept HIV-disabled persons from receiving benefits of a program designed to help them. The legislation would establish a panel of researchers, practitioners and advocates who are experts on the development and treatment of HIV/AIDS in women, children and substance abusers. The panel would recommend changes in the current disability definition for both SSI and SSDI, update the SSA on medical research and treatment of HIV positive persons, report the appropriateness of how disability determinations are made and what conditions should be included on the listing of impairments, which the SSA would implement into new regulations. The legislation would also require SSA to collect demographic information on HIV positive persons who apply and are denied SSI and SSDI benefits. H.R. 2299 would provide the SSA with up-to-date information regarding medical research for HIV positive persons and require SSA to collect data on the numbers of women, children and substance abusers who apply for and are denied SSI and SSDI benefits.

Thank you for the opportunity to include our statement within the printed record.

STATEMENT SUMMARY

While SSA may be attempting to develop standards appropriate for disability determinations, the published standards create several obstacles for disabled claimants to meet the requirements. The problem areas include:

1. Gynecological impairments omitted from the listings;
2. Listed conditions requiring a high degree of severity;
3. T-cell count requirements that appear arbitrarily set;
4. Functional tests that are inappropriate and difficult to document;
5. Documentation requirements for conditions persistent and/or resistant to therapy which may deprive many low income people from obtaining benefits who do not have access to consistent primary care; and
6. The functional limitations, section G, of the physicians report on allegations of HIV infection requires medical personnel to make subjective judgments because the terms are not defined on the form.

SSA should revisit all of the aforementioned issues before adopting a final regulation. Without changes, low income persons, women and substance abusers will not be afforded an equal opportunity to qualify for social security disability benefits based on their HIV related disabilities.

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TESTIMONY OF NATIONAL INDIAN COUNCIL ON AGING

On behalf of the National Indian Council on Aging, the Washington State Indian Council on Aging, and low-income, elderly clients of the Native American Rights Fund and Evergreen Legal Services we wish to voice our strong support for your efforts to assure that low-income, disabled and elderly Americans have full access to the SSI, Medicare Part B, and Medicaid programs, and that unreasonable barriers to these benefits be removed. We particularly draw your attention to the unique plight of elderly, low-income Native Americans who often are caught in the middle of federal agency battles over which program is going to provide services to them, or harmed by federal program policies which too often disregard Indian culture or the unique legal status of Native Americans in our country.

Our organizations have long been aware that many older Indians do not participate in the SSI, Medicaid, or Medicare Part B program because of lack of information about the programs and/or because of procedural or policy barriers which effectively preclude their participation. For many years but particularly throughout 1990 and 1991 our organizations have attempted to bring these issues to the attention of federal agencies and of Congress. Below is a summary of our efforts including testimony before four Congressional Committees. Testimony from the earlier Congressional hearings is attached as Exhibits A and B. We ask that the Committee carefully review that more comprehensive and detailed testimony and include it in the present official hearings record.

1) The National Indian Council on Agency is involved in a two-year, Administration on Aging-funded SSI outreach project to increase the participation of Native American elderly in various human services and entitlement programs, and most importantly SSI, Medicare Part B, and Medicaid, through training of local community services coordinators to conduct on-going benefit enrollment campaigns in Indian communities.¹

2) Washington State Indian Council on Aging (WSICOA) is in the second year of a related Administration on Aging-funded project designed to document and publicize the most common policy or procedural barriers which keep older Indians from participating in federal needs-based assistance programs.² Results of an eight-tribe survey of older Indians is expected to be released in June 1992.

3) In 1991 Walter Echo-Hawk of the Native American Rights Fund and M. Helen Spencer of Evergreen Legal Services testified jointly in behalf of affected clients before the Senate Select Committee on Indian Affairs and House Interior and Insular Affairs Committee on S.754 and H.R.2737. These bills which address one of the common, chronic barriers to SSI and other programs faced by older Indians and that problem is counting of income from individual trust lands. The bills would provide a \$4,000 per year exemption for income from Bureau of Indian Affairs-managed individual Indian trust land. Counting of the small, irregular lease and grazing income by SSI has caused mental and physical

¹NICOA, in the second year of the project, has demonstrated that participation in the SSI programs can be particularly greatly increased by enhanced, culturally appropriate enrollment efforts. In the first year of the project SSI enrollment in 7 targeted communities increased by one third, and in several of the smaller included communities, doubled.

²Working with Washington state-based Advocates for Tribal Elderly and Evergreen Legal Services, WSICOA has recently conducted interviews of Indian elderly of eight Indian tribes: Yakima, Colville (Washington), Umatilla (Oregon), Northern Cheyenne (Montana), Standing Rock Sioux (North and South Dakota), Penobscot (Maine), Sac and Fox (Oklahoma), and Bear River Mattole Wiyot (California). The Project is also developing an advocates manual to assist attorneys and Indian advocates in representing older Indians who have problems accessing the federal entitlement programs.

hardship through repeated overpayments or, alternatively, loss of SSI and Medicaid payments, causing many older Indian to quit the programs in frustration. A copy of the NARF and Evergreen October 22, 1992, testimony and listing of tribal and organizational support for the exemption bills is attached as Exhibit A.

4) Elizabeth White, speaking for the Washington State Indian Council on Aging, testified on May 4, 1991, before a joint field hearing of the Senate Labor and Human Resources Committee Subcommittee on Aging, and the House Education and Labor Committee Subcommittee on Human Resources, and included in her testimony a description of common barriers to receipt of Social Security benefits and SSI benefits experienced by older Indians. That portion of her testimony is attached as Exhibit B.

5) Many of the SSI issues addressed below were also presented to the SSI Modernization Project by M. Helen Spencer and Yakima tribal elder Sadie Long at the project's Los Angeles hearing in March 1991.

As the above listing of projects and testimony demonstrates, our organizations are currently devoting intensive levels of effort to addressing the same issues which your Subcommittees now examine. We thus hope that you will carefully consider the listing of access problems faced by older Indians which follows:

A. Lack of Adequate Outreach

The SSI, Medicaid and Medicare programs rely primarily on written materials to describe their programs and eligibility requirements. There is little physical outreach of SSA personnel to Indian communities. Many low-income older Indians still speak their own languages and have minimal or no English reading skills. They are very unlikely to learn of programs through written information. The Indian languages are, for the most part, not written languages, so written translations materials are not an option. Many older Indians do not have telephones, so there is little possibility that application or eligibility reviews can be done by telephone.

Older Indians commonly feel they must travel to the Social Security or welfare office to get a clarification of a letter, or an answer to a question, or to travel to their legal aid lawyer or tribal social worker. Often they must pay someone else to drive them as there is little public transportation and many tribal elders either have no vehicle or are no longer able to drive. In addition unless they take along a translator they may never get the information they need, as the Social Security offices have no translators for Indian claimants.

B. Barriers to Entitlements

a. Program Income and Resource Restrictions Have a "Chilling Effect" on Older Indian Participation.

We will discuss below a number of recurring problems older Indians face with SSI, Medicaid Part B, and Medicare, but first we wish to make clear that the programs have a reputation in the Indian community for giving older Indians problems over Indian assets which are an intrinsic part of their identity and life. Thus many, many older Indians refuse to even apply for needed benefits because of the negative experiences that others have related.

b. Excessive Paperwork Discourages Elderly Indians

Because low-income Indian elderly commonly have limited reading skills, the application process for programs is especially intimidating. This intimidation is increased by the fear that they might fill out something wrong, or otherwise be asked to payback the benefits they get.

c. Specific Barriers to SSI, Medicaid, Medicare

i. SSI Indian Resource Issues-Regalia,
Traditional Artifacts

Older Indians are seldom willing to sell traditional heirlooms, regalia, or artifacts in order to obtain federal benefits. Traditional artifacts or clothing that are an intrinsic part of the tribal culture should not be counted as excess resources. Making elders choose between selling heirloom buckskin dresses and obtaining SSI and Medicaid is patently unjust.

ii. Fishing Equipment, Sheep, Farming
Equipment

As with trust income, fishing income and agricultural income from individual Indian lands is tax-exempt and protected by federal statutes and treaties. While SSI regulations do allow for ownership of some income-producing assets, the regulations are often too narrow, or too narrowly interpreted to allow older Indians to continue their traditional occupations, such as fishing or sheepherding. Thus, although the older Indians can no longer make significant income, they may wish to retain their few head of sheep, or little-used fishing boat and maintain their traditional lifestyle rather than receive federal benefits. We believe they should not have to make these choices and that their income-producing resources should be exempt.

iii. Income From Individual Trust Lands
and SSI

While much Indian land has passed out of individual Indian ownership, more traditional tribal members have retained their lands against considerable odds. The trustee of those lands is the federal government and the lands are promised by treaties and statutes to be preserved for the "full use and benefit" of the landowners. That income from these lands must be repaid to the trustee is incomprehensible to us and to older Indians. The irregular monies cause constant concern and frequent interruption of SSI, Medicaid and Medicare Part B.

We have learned that the SSI Modernization Project will recommend exemption of individual trust income and ask your committee to recommend passage of H.R.2737 this session.

When SSI stops, Medicaid often stops and states who pay Medicare Part B stop those payments as well. Older Indians will turn to Indian Health Services rather than applying for QMB eligibility, and because of limited IHS funding will lose adequate coverage for cataract surgery, eyeglasses or hearing aids.

1991 SSI regulations instruct states to stop Medicaid for SSI participants who lose income because of payment of debts. Because many older Indians borrow against lease income when they lose SSI or when other emergencies occur, their lease income may be claimed by the tribal credit program, leaving the Indian elder ineligible for SSI or Medicaid, and without lease income. There is no safety net for Indian elderly.

IV. Social Security (Title II) Barriers to Benefits Including
Medicare Part A

Indian elderly commonly have difficulty proving their birth or age as many were born at home and/or married in traditional Indian ceremonies, without written records. SSA's refusal to accept Bureau of Indian Affairs documentation of age, in the absence of a birth certificate, discourages older Indians from pursuing Title II claims. Similarly many surviving spouses have been denied Title II benefits because SSA would not accept statements as to the nature of and the fact of the couple's marriage, or have disallowed the marriage based on early tribal code provisions some of which have been effectively overridden by later codes or tribal court decisions.

In general, participation in Title II retirement or survivors benefits is low among older Indians because they worked in agricultural occupation which did not pay into Social Security or because they engaged in fishing or farming activities producing tax exempt income (under treaty and federal allotment act provision) and thus did not file tax, or accompanying self-employment, forms.

Lack of Medicare Part B and Medicaid Coverage Due to HCFA/Indian Health Services Relationship

Finally we would like to bring to your attention the great need for HCFA to cooperate with the Indian Health Services and Indian tribes in reducing the barriers to health care which older and disabled Indians face.

Currently tribal members who seek medical coverage from Indian Health Services' Contract Care Program are required first to apply to Medicaid, or their state's equivalent program. Only if they are denied Medicaid coverage are they eligible for IHS's Contract Care coverage. Many, many older Indians fail to obtain any coverage because they are unable or unwilling to complete the Medicaid application within the given timelines. We are asking HCFA to work with IHS to allow IHS or tribal workers alone, or together with state workers, to make the Medicaid eligibility determinations of the IHS or tribal facility so that older Indians do not have to apply separately to both programs for each medical bill.

Similarly, we are asking that HCFA participate with IHS on QMB coverage so that IHS can process QMB applications for Indian claimants without requiring a separate QMB application process at a separate location.

Thank you for this opportunity to present this information to your Subcommittees.

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Attachment A

(Index for)

BRIEFING MATERIALS FOR

S. 754 H. R. 2737

LEGISLATION CONCERNING THE TREATMENT
OF INDIVIDUAL INDIAN INCOME DERIVED
FROM TRUST LANDS

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NORTHERN ARAPAHOE BUSINESS COUNCIL, Letter from Chairman Burton Hutchinson: "The continual flip-flop of eligibility status increases the hardship on tribal members and the risk that they will miss opportunities for benefits..."

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COLORADO RIVER TRIBAL COUNCIL, Resolution: "...the Tribal Council supports efforts to

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AFFILIATED TRIBES OF NORTHWEST INDIANS, Resolution: "...the harsh treatment of trust income, which may average as little as \$420.00 per year...must come to an end..."

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FORT PECK TRIBAL EXECUTIVE BOARD, Resolution: "[The] practice of the Social Security Administration, the Veterans Administration, the Bureau of Indian Affairs and other agencies causes great hardship, mental distress, anguish and actual physical harm to tribal members and tribal elders in particular ..."

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BLACKFEET NATION, letter: "The Blackfeet Tribe fully supports S.2995, the Trust Income Exemption Bill recently introduced by the Senate, and requests that your committee approve it."

B39

COLVILLE CONFEDERATED TRIBES, Letter: "S.2995 will statutorily guarantee that our most needy tribal members will receive at least a reasonable amount of benefit from their trust money."

B40

CONFEDERATED TRIBES AND BANDS OF THE YAKIMA INDIAN NATION, Letter: "While we are firmly convinced that all individual trust money should be exempt for purposes of entitlement programs, under the same trust principles that protect that money from taxation, we have observed the suffering of tribal elders for too long, and now support this compromise legislation."

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 Resolution: "[The board] calls upon the
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 H.R.2737: "If tribal elders with fractionated
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 Congress to enact it into law in 1991.

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 support of S.743: "Right now this policy
 causes denial of services and benefit to this
 group, further impoverishes an already poor
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TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS:
 Letter in support of S.754: "Our BIA social
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 budget tracking irregular and small amounts of
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 lost badly needed benefits because of these
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B51

DEVILS LAKE SIOUX TRIBE: Letter in support of
 S.754: "The underlying compensation
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B52

OKLAHOMA INDIAN COUNCIL ON AGING: Resolution
 in support of S.754: "This legislation is

very important to many of our elder Indians..."

B53

AFFILIATED TRIBES OF NORTHWEST INDIANS:
Resolution in support of S.754: "Now therefore be it resolved, that the Affiliated Tribes of the Northwest Indians calls upon the Oregon, Washington, Montana and Idaho Congressional delegations to support S.754 and companion House legislation."

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NATIONAL AMERICAN INDIAN HOUSING COUNCIL:
Resolution in support of S.754 and H.R.2737.
"[Legislation will] end for financial, physical, and emotional harm caused...."

B56

INTER-TRIBAL COUNCIL OF THE FIVE CIVILIZED TRIBES; Resolution in support of S.754:
"....[our] citizens are wrongfully being denied service due to a misunderstanding of this trust status of their lands and income...."

B57

GREAT LAKES INTER-TRIBAL COUNCIL, Resolution in support of H.R.2737 and S.754:
"...[Legislation] will correct inequities and implement the federal trust responsibility for the benefit of elderly, disabled, and low-income tribal members."

B58-59

C. BIA LETTERS OF SUPPORT

ABERDEEN AREA DIRECTOR JERRY JAEGER: "An almost unimaginable number of man hours goes into the steady effort of [verifying] trust income...[T]he income per case is not of sufficient amount to justify this immense effort."

C1-2

SUPERINTENDENT WILLIAM SANDOVAL, Umatilla Agency: "For years, I have felt that these funds should be exempt..."

C3

SUPERINTENDENT GORDON CANNON, Northern Idaho Agency: "...[W]e are confronted with individuals and families without income...due to meager lease income received [the prior year]. (Chart shows individual with only 31/6912 interest in one allotment.)"

C4-7

SUPERINTENDENT EDWIN MILLER, Lower Brule Agency: "The vast majority of our clients receive less than two hundred dollars a year."

C8-9

SUPERINTENDENT HIRAM OLNEY, Yakima Agency:
"All trust income should be protected as part
of the trust responsibility."

C10-11

SUPERINTENDENT MIKE FAIRBANKS, Pine Ridge
Indian Agency: "Federal Law should not
interfere or restrict this process [of elders
sharing trust income with grandchildren], nor
should it monetarily punish the Indian elders
for doing what they feel is right and proper
and in keeping with their beliefs and
traditions."

C12

SUPERINTENDENT TERRANCE C. WALTERS, Turtle
Mountain Agency: "Most individuals on this
reservation who receive SSI are underpaid or
not paid based on Social Security
Administration's use of lease income for prior
years."

C13

SUPERINTENDENT WILLIAM GIPP, Blackfeet Indian
Agency: "Our Agency is currently providing
approximately 1,000 trust income verifications
per month which takes up one full-time staff
position."

C14-15

SUPERINTENDENT RUSSELL MCCLURE, Cheyenne River
Agency: "One has to question whether we
really are providing clients a service [in for
BIA-GA] and are their basic needs being
met..."

C16-17

ACTING SUPERINTENDENT TIMOTHY C. LAKE,
Sisseton Agency: "We have many elderly that
go without income for several months at a
time..."

C18

SUPERINTENDENT WM. LYNN ENGLES, Flathead
Agency: "...tabulating small amounts of lease
income from fractionated tracts for
determining entitlement to Federal and/or
state programs is not cost effective."

C19

SUPERINTENDENT CORA L. JONES, Rosebud Agency:
"...I strongly feel that all trust income
should be exempt...over 70 percent...receive
less than \$200.00 per year...over 50 percent
receiving less than \$50.00 per year..."

C20-26

ACTING SUPERINTENDENT ROBERT DONLEVY, Pima
Agency: "This Agency has only two full-time
IIM clerks...[trust income verifications]
require some three to four hours each day..."

C27

ACTING AREA SOCIAL WORKER JOE PARADISE, Portland Area Office: "Such extreme poverty often causes other serious dysfunctional problems with the effects ranging from distressful to fatal.... So long as our staff is required to use estimates of trust income, the BIA-GA program will not have the capability of correctly paying GA recipients.. .."

C28-29

FORMER SUPERVISORY SOCIAL WORKER FOR YAKIMA AGENCY, FORMER MEDICAL SOCIAL WORKER AT PINE RIDGE, Timothy Oliver: "If they [tribal elders] have no income (neither SSI nor trust income) their mental health and their physical health are adversely affected. If they do get the SSI and end up being overpaid because of trust monies, they are also under stress and very upset. Either way, their mental health suffers and the quality of their lives is diminished."

C30-34

PORTLAND ACTING AREA DIRECTOR WILFORD BOWKER: "Because of the many conflicts between BIA policies and SSI policies, and the overriding trust responsibility I believe SSA should cease counting trust monies to reduce SSI benefits."

C35-36

SUPERINTENDENT WYMAN D. BABBY, Fort Peck Agency: "Trust income, in the vast majority of cases, plays an extremely minor role in meeting the financial needs of Indian people. However, because we are forced to rely on estimates....the system breaks down immediately."

C37-39

SUPERINTENDENT TIMOTHY LAKE, Sisseton Agency: "Some welfare agencies require verification on a monthly basis, as do some nursing homes. If these services are terminated..."

C39-40

SUPERINTENDENT DAN DURINWATER, Yankton Agency: "Yankton Agency supports any and all attempts to obtain exemptions of trust funds for income regulations for Federal, State and Bureau Programs."

C41

ACTING SUPERINTENDENT, Lower Brule Agency Supplementary Statement): "The staff agencies routinely request this information or a negative report [if no trust income] for any Indian applying for assistance... [which] reports involve almost as much time to process as one with information to report."

C42

NORTHERN CHEYENNE AGENCY, Superintendent Kenneth Davis letter: "I strongly support your efforts to help secure an exemption of Indian trust income for SSI and other needs-based programs."

C43-44

D. "SUGGESTIONS" FROM SSA/STATE TO BIA ON TRUST INCOME ISSUES

FORMER COMMISSIONER OF SOCIAL SECURITY DORCAS R. HARDY: "Perhaps a tribal council member with access to information regarding individual trust income distributions could be designated to help assure that the reports are made to us as soon as possible."

D1-2

ASSISTANT ATTORNEY GENERAL FOR THE STATE OF SOUTH DAKOTA MARK L. BRATT, providing form letters for BIA use and explaining that the State of South Dakota plans to closely monitor according to AFDC standards) BIA superintendents' decisions regarding minors' supervised IIM accounts: "This documentation [form letters with written explanation by superintendent as to why money was not released] would allow the Department to re-examine the 'availability' of []'s IIM income."

D3-7

E. PETITIONS FROM SENIOR CITIZENS OF GILA RIVER INDIAN COMMUNITY TO ASSISTANT SECRETARY BROWN

LETTER FROM COMMITTEE CHAIRMAN ARTHUR T. LAMORE with 112 signatures attached; separate letters from Senior Citizens of District 1 (200 members), District 2 (30 members), District 3 (56 members), District 5 (75 members), District 6 (90 members), and District 7, (52 members), all supporting legislation to exempt \$4,000 per year in individual trust income.

E1-12

F. OTHER INFORMATION DOCUMENTING NEED FOR EXEMPTION OF TRUST INCOME

LETTER FROM RAYMOND B. LITTLE, CHIEF ADMINISTRATIVE LAW JUDGE, SEATTLE OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, discussing the numerous (and expensive) hearings which challenge SSI's counting of trust monies: "The main problem with these cases is the amorphous state of both statutory and court decision law on the subject. It would clearly be much more efficient and cost effective if the uncertainty and confusion were removed by remedial legislation."

F1

EXCERPTS FROM INVESTIGATION HEARING ON NATURAL RESOURCES ON INDIAN LAND, SPECIAL COMMITTEE ON INVESTIGATIONS, May 12, 1989, Testimony of Steve Moore, NARF: "[I]n the case of people like Mary Limpy [enrolled member of Cheyenne Arapaho Tribe of Oklahoma]..., if say \$3,000 or \$4,000 of lease income [were] exempted... she could look forward to regular receipt of those benefits..."

F2-6

CHRIS VALDA, DIRECTOR, Four River Indian Legal Services: "Recipients receiving AHCCCS acute care, when found ineligible for SSI, [because of lease income] are automatically terminated from the AHCCCS program. The individual must reapply for AHCCCS and is required to go through the full eligibility determination process [which requires a visit to the off-reservation county office]. [He or she may then be denied AHCCCS if the State Arizona believes IHS should provide coverage.]"

F7-8

KATHLEEN MARX, FORMER MANAGING ATTORNEY, Montana Legal Services, Browning, Montana: "... Client [blind and without running water]...was hesitant in borrowing money [to repair her broken water pipe] and assigning her trust income as collateral because she knew it would result in a reduction of her SSI benefits."

F9-12

DOUG OLNEY, DIRECTOR, Yakima Nation Area Agency on Aging: "I'm sure that other tribes who see this problem also respond as well as they can with financial, food, or legal services, and emergency transportation, whenever elders lose needed benefits..."

F13-14

R. SAWREY A., FINANCIAL ANALYST, REGISTERED REPRESENTATIVE: Discussing 1975 "Indian Income Disregard Study" funded by HEW (now HHS) which concluded that it would be cost effective to exempt \$2,500 per year in Indian monies for purposes of SSI and AFDC: "...[I]n terms of purchasing power of basic goods and services the impart of \$2,500 income in 1975 is roughly equivalent to that of \$5,781 in July of 1989."

F15-18

MARIAN RABANAL, MANAGER, Wanity Park (Tribal Senior Citizen Housing): "[Suspension of SSI benefits] too often causes a large hardship on the tribal elder...I am particularly concerned about those with special dietary needs, [and also the] emotional stress, causing physical

harm to elders with heart and diabetes problems."

F19

STEVEN L. BUNCH, DNA-PEOPLE'S LEGAL SERVICES:

"Many people, particularly the older people and people not fluent in English, don't understand this recoupment process and are not successful at handling it. This may result in excessive and wrongful reductions in their subsistence allowances. Also, as the income from trust allotments is intermittent but the administrative procedures are rather lengthy the current policy puts these people in a never ending revolving door of administrative recoupment proceedings."

F20-22

STATE OF MONTANA, DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, letter: A great deal of time is spent in verifying lease payments, which are very small in nature. We believe that passage of this bill will result not only in saving administrative time and money, but will benefit the clients as well."

F23

WASHINGTON ASSOCIATION OF CHURCHES, letter:

"The lands are so fractionated that income from those lands will become only more unpredictable and divided as time goes by. The hardship to elders caused by counting this money can only increase as time goes by. This legislation is long overdue."

F24

STATE OF IDAHO, DEPARTMENT OF HEALTH AND WELFARE, letter:

In describing verification of income from trust lands leased by multiple number of owners, "Administratively this is a nightmare...It does appear that we are spending a great deal of time to save a little bit of money."

F25-26

NEW MEXICO HUMAN SERVICES DEPARTMENT, letter:

"We have frequently checked (IIM) accounts relative to many hundreds of our clients and it is our carefully considered opinion that is not worth the effort...We strongly urge that these monies be exempt as income or resources when determining eligibility for public assistance."

F27

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, letter:

"I request your support in the passage of the Trust Income Exemption Bill S.2995....a survey of field offices shows that there are only two persons in the last several years whose eligibility

[for state benefits] would be affected." F28

STATE OF NEVADA, DEPARTMENT OF HUMAN RESOURCES, WELFARE DIVISION, letter: "contacted our rural districts which have Indian case loads.... Only Elko has had one case over the years [with] income...from restricted land." F29

G. STATEMENTS REGARDING SSI PRACTICES SUBMITTED FOR SSI HEARING RECORDS

Letter from Aberdeen Area Director Jerry Jaeger: "[C]urrent SSI policies are especially in conflict with BIA policies and cause harm and uncertainty for elderly and disabled Indian people..." G1-2

Letter from Acting Portland Area Director Wilford Bowker: "SSI policies also conflict with the BIA responsibility to manage trust lands to the benefit of Indian people." G3-4

Letter from Billings Area Director Richard Whitesell: "Individual trust money should be exempt for SSI purposes in keeping with the Federal trust responsibility that is owed to vulnerable elderly, blind, and disabled tribal members..." G5-6

Letter from Acting Portland Area Social Worker Joseph Paradise: "In many if not most cases all amounts of lease money are offset by loss of SSI benefits in a manner that creates month by month instability in income...It is bad social work to knowingly cut their income back to well below a subsistence level of living..." G7-9

SSI Claimants Talk of the Frustration and Hardship SSI Policies Create for Them. G10-20

EXHIBIT A

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before the House Interior and Insular Affairs Committee
H.R. 2737, Legislation Concerning the Treatment
of Individual Indian Trust Income for Purposes
of Federal Needs-Based Program

October 22, 1991

Mr. Chairman and members of the Committee, this is the testimony of Helen Spencer of Evergreen Legal Services/Native American Project and Walter Echo-Hawk of the Native American Rights Fund. We represent more than 30 low-income Indian elderly people who would greatly benefit from H.R. 2737. We are grateful for this opportunity to provide testimony in strong support of H.R. 2737 and again in support of its companion bill, S. 754. We especially thank Representative McDermott, Chairman Miller and Committee Members Rhodes, Campbell, and Johnson for their co-sponsorship of this important bill.

Congress has exempted all other types of Indian trust monies in the calculation of federal entitlements. Only the income from individual Indian trust land is left unprotected in calculation of federal needs-based benefit. We are aware that this omission was an oversight. H.R. 2737 would provide a partial (\$4,000) exemption for individual Indian income derived from trust lands and would, thereby, extend the same treatment to this income as is provided all other income derived from trust land. It would also be wholly consistent with the treatment Congress has extended to many other types of incomes which are not specific to Indian people.

Support for H.R. 2737. Accompanying our testimony is a 181-page briefing book which contains numerous letters from Bureau of Indian Affairs (BIA) Superintendents, Area Directors and social workers documenting the conflict between the BIA's responsibility to protect trust resources, and trust income, versus the harmful federal policy of counting small amounts of erratic individual Indian trust income toward eligibility for federal programs.

This exemption is consistent with federal Indian policy and court decisions which require that Indian resources be protected for the benefit of Indian people. Further, the fact that the exemption would benefit only one discreet group of SSI recipients is consistent with other SSI exemptions. Many existing exemptions benefit only a portion of all SSI recipients. For instance, not all SSI recipients own their own homes and thus have lower shelter costs; not all SSI recipients own their own vehicles, nor burial plots, nor do all have \$2,000 in their savings accounts. And, of course, not all SSI veterans receive Agent Orange settlement money, nor do all Japanese SSI recipients receive internment payments, nor do all Indian SSI recipients receive per capita payments.

The briefing book also contains 30 or more resolutions and letters of support from tribal governments and organizations, and letters of support from state officials, advocates, and affected individuals. The attached book is an impressive array of support for H.R. 2737, and we ask that it be made part of the official hearing record. (Attachment A.)

Also attached is a listing of types of income which the SSI program disregards in the calculation of its benefits. This information provides important context regarding the equity of protecting individual Indian trust income. Each exemption benefits a different group of SSI recipients who happen to have that particular source of income or own that particular resource. (Attachment B.)

Our testimony is divided into three sections:

I. A description of why it is a matter of equity to provide this exemption for a limited amount of individual Indian trust income;

II. The historical background of why there exists individual Indian trust income and the federal trust responsibility toward Indian people, including their lands and income; and

III. Discussion of several federal benefit programs and how they treat individual Indian trust income. This treatment creates a serious conflict between the BIA's goals and responsibilities and the present policies of the federal entitlement programs.

I. It is a Matter of Equity

Federal entitlement programs have long been asked by Congress and the courts to accommodate, through income and resource exemptions, competing federal goals and public policy in their programs as a matter of fairness to particular populations. Examples of this are the exemption for payments to Holocaust victims, to Japanese internees, to Aleut people relocated during World War II, and to Agent Orange victims.

Congress has also protected on grounds of equity all Indian trust monies except the individual trust monies at issue in H.R. 2737. It is an oversight, and an inequity that these monies do not receive the same protection as income generated from tribally owned trust lands.

Our testimony will demonstrate that repeatedly benefit eligibility regulations of general applicability harm Indians with individual trust income. That is an inequity that H.R. 2737 would help to correct.

II. HISTORICAL BACKGROUND/TRUST RESPONSIBILITY

Individual trust income cannot be accurately described or categorized outside of its historical context. Much of this income is derived from lands reserved by tribes in treaties with the United States government. Often the same treaty land is also part of federal government's allotment policies of the turn of the century. In all cases the land at issue in H.R. 2737 is held in trust by the United States government for the exclusive use and benefit of the individual Indian landowners.^{1/}

The United States is trustee for these lands and their income: the income must have extraordinary protection.

Treaty Lands. A significant portion of the land and income at issue here is part of aboriginal lands reserved by Indian tribes according to the terms of the Indian treaties of the last century.^{2/} In those treaties the government sought to extinguish title to much of the Indians' aboriginal lands to make more room for non-Indian settlers. Not surprisingly, far more land was ceded to the United States than was reserved for the tribes.^{3/} In return, the tribal members typically were assured a variety of goods and services and were promised full protection for their reserved lands.

The Yakima Treaty of 1855 is typical of many treaties in the Northwest.^{4/} In that treaty approximately 1.3 million acres of land was reserved for the Yakima Nation, but more than 10 million acres of surrounding land was ceded to the United States. In exchange for this large cession of land, the Yakima people received minimal compensation and the guarantee of off-reservation hunting, gathering, and fishing at accustomed locations, plus on reservation homes, schools, job training, medical services and a hospital, a sawmill, and the "exclusive use and benefit" of their reserved lands. For the Yakima Nation, as for other tribes, treaty provisions have too often been ignored or undermined due to competing federal and private interests. The present policies which count income from treaty lands to harm disabled and elderly tribal members is yet another outrageous example of this.

General Allotment Act Policies. The tribes' right to "exclusive use and benefit" of their reserved treaty lands was undermined soon after signing of the treaties by the General Allotment Act of 1887 and related laws and policy. The General Allotment Act resulted in the loss of nearly two-thirds of all Indian lands, approximately 100 million acres. By the end of the allotment period (1934) approximately 100 million acres had fallen into non-Indian ownership. Two-thirds of the total allotted land was sold by allottees, often by way of "forced fee patents," and an additional 60 million acres were either ceded outright or sold to non-Indians as "surplus lands."^{5/} Today only 10 million acres of trust land remain in individual Indian ownership, about 6% of the acreage owned by tribes prior to the allotment period.^{6/} A small percentage of these landowners are low-income, disabled, elderly people who seek assistance from federal benefit programs.

Indians retaining larger interests in individual Indian lands, particularly the remaining allotted lands, are very often more traditional tribal members such who have maintained their culture and language and speak little English. This is no coincidence as they often have inherited the lands from parents who themselves spoke little or no English. This is so, in part, because one feature of the allotment policy was that mixed-blood Indians or Indians with any significant degree of education or English proficiency were considered "competent" by the Federal Government. The Government issued "fee patents"^{7/} to persons deemed "competent" (meaning that the land was subject to taxation). The direct and nearly immediate consequence for many was seizure of the land in tax foreclosures or loss to unscrupulous buyers. Generally, full blood Indians and those without formal education were not considered

"competent", and their lands were not issued fee patents, a circumstance which increased the chances of the land remaining in Indian hands.

Clearly, the status of individual Indian lands and their income is inextricably tied to the history of relations between the United States government and Indian people. In present day Indian affairs two features of individual trust land and trust income still receive intense congressional and judicial scrutiny: 1) the Federal trust responsibility -- the high fiduciary standard that the federal government owes each Indian landowner to manage trust lands to the best benefit of the Indian owners, and 2) fractional land problems -- the disproportionately high administrative cost of managing individual trust lands that have become incredibly fractional over the years (i.e., owned jointly by dozens or even hundreds of heirs).

Federal Trust Responsibility. A central attribute of individually owned Indian lands is that they are now intensely managed and protected by the federal government according to the highest fiduciary standards. This high standard of care was reinforced by the United States Supreme Court in a 1983 case involving timber sales on the Quinault Indian Reservation called United States v. Mitchell.^{8/} The Court found that the Bureau of Indian Affairs could be sued for damages for breach of trust if it failed to manage resources so as to generate reasonable proceeds for the Indian owners. The protections of the federal trust responsibility extend to income from the protected trust lands and not just to the land itself.^{9/} The Mitchell case turned on the high degree of federal management of timber lands under Bureau of Indian Affairs statutes and regulations. The BIA's trust responsibilities for management of individual Indian farming, grazing, and mineral lands is equally as all encompassing as that for timber lands.^{10/}

Before the 1983 Mitchell decision, the United States Supreme Court in 1956 had determined in Squire v. Capoeman ^{11/} that taxation of timber proceeds was inconsistent with the General Allotment Act's promise to transfer trust property at the end of the trust period to the individual Indian owner "free of all charge or encumbrance whatsoever."^{12/} The Internal Revenue Service offered the same arguments in Capoeman as the Social Security Administration standardly offers for SSI's treatment of these monies: 1) because there is no express exemption for trust income in the General Allotment Act or any other statute, money was not exempt for IRS purposes, and 2) taxing income from the land is not as intrusive as taxing the land itself. The Supreme Court disagreed.

In light of the language of the Capoeman and Mitchell cases, Indian people are more than justified in believing all trust income should be as protected for federal entitlement purposes just as it is for tax purposes. Certainly the treatment of the trust monies by the entitlement programs, as you will learn, creates much greater hardship than would federal taxation of the same funds.

The federal trust responsibility applies to all federal agencies, not just to the Bureau of Indian Affairs. Just as the Supreme Court protected timber proceeds from taxation, the Ninth Circuit in Nance v. Environmental Protection Agency ^{13/} reminded the Environmental Protection Agency that it, as a federal governmental agency, had a duty to act according to the "strictest fiduciary standard" in regard to

Indian lands and thus had to modify its own policies to accommodate Indian interests. If the IRS and EPA are bound by this highest moral duty, why should the federal entitlement programs not be required to provide at least the reasonable exemption for individual trust income that H.R. 2737 would mandate?

The federal trust responsibility is not limited solely to protection of natural resources. Just as protection of Indian children is acknowledged as being part of the trust responsibility, so must elders be acknowledged as being protected. The elders of our tribes are the glue which holds together not only our diminished tribal lands, but also our tribal identity and our tribal purpose.

Fractional Lands Problems. The second key attribute of individual trust income is that it constantly diminishes because the land has ever increasing numbers of joint owners as it is inherited by succeeding generations. There are often dozens of Indian owners for any one allotment (the original allotments were commonly 80 acres of agricultural land or 160 acres of grazing land). Management of these badly fractional parcels is an administrative nightmare for the Bureau of Indian Affairs, and the administrative costs of renting the land and distributing the income often far exceeds the value of the land.^{14/} Yearly payments to each joint landowner are often only \$10 or \$20 per year, or even less.^{15/}

Because of the administrative inefficiency for the BIA of managing small fractional shares of trust land, and the tribes' interests in consolidating fractional reservation lands in the economic interest of the tribes, Congress enacted the Indian Land Consolidation Act of 1983 ^{16/} to allow very small interests in trust land to pass to the tribes, instead of to the heirs upon the death of the owner. It will take years to determine if the consolidation efforts will be successful.^{17/}

III. FEDERAL PROGRAMS' TREATMENT OF INDIVIDUAL INDIAN TRUST INCOME/CONFLICT OF INTEREST BETWEEN POLICIES AND THE UNITED STATES GOVERNMENT ROLE AS TRUSTEE

What Does the Trust Responsibility Mean in Terms of Day to Day Management of Indian Trust Resources by the BIA

The supervision of trust lands involves many branches of BIA reservation operations. On reservations with individually-owned trust lands, the BIA branch of leasing will advertise for lease of trust lands, negotiate lease terms, obtain landowners permission to lease lands, and distribute income from the lands to the joint owners. Payments to each owner is deposited in his or her Individual Indian Money (IIM) account at the same agency or, if the person is enrolled in another tribe, transferred to that agency.

If the BIA superintendent has authorized assignment of the deposited funds, the funds will held for transfer to the tribal credit program. If landowner is unable to manage his or her own money, the IIM account will be "restricted" and funds will be supervised by the BIA branch of social services.^{18/}

The many letters in the briefing materials from BIA Superintendents, social workers and Area Directors, document the enor-

mity of the conflict of BIA goals and responsibilities with the policies of federal entitlement programs. The harsh treatment of the Indian lease money by the federal programs makes it impossible to manage the lands in a manner that benefits all landowners, while creating an enormous book-keeping burden on the BIA. Low-income tribal members, who most need their trust income, are often denied any opportunity to improve their lives with the money from their trust lands as it is deducted from their federal benefits. They would, in fact, be better off if the land were not leased.

Private Trust Funds versus Indian Trust Funds. The federal Indian trust doctrine is a political and historical doctrine at the core of federal Indian policy, and cannot be compared to any meaningful extent to private trust relationships arising out of private contracts and agreements. The federal government is the trustee for Indian resources and income; it is not the trustee for private trust funds.

The doctrine of federal trust responsibility, especially in regard to Indian lands, is unique and arises in main part out of Indian treaties and Indian statutes. The doctrine has been developed by federal courts using Indian law principles, and only incidentally borrowing legal standards applicable to private fiduciaries ^{19/} With and without invocation of private trust principles, the federal government has been consistently recognized as the "trustee" of Indian resources, whether tribally or individually owned.^{20/} Again, there simply is no analogous federal involvement with non-Indian owned lands, funds or assets. ^{21/}

SSI Treatment of Trust Income. The Supplementary Security Income (SSI) program is a needs-based program administered by the Social Security Administration to provide financial assistance to the nation's aged and disabled. The SSI program currently gives favorable treatment to private trust funds and unfavorable treatment to Indian trust funds. For example, money in a private trust account that is spent on behalf of an SSI recipient for other than food, shelter or clothing will not be counted for purposes of determining SSI eligibility. Thus, a private trustee can purchase a vehicle for the trust beneficiary with no negative impact on SSI benefits. Indian trust income, however, is counted regardless of how it is spent.

Further, the fact that the BIA manages the agricultural lands for Indians puts their income in SSI's less favorable "unearned income" category, while those with income from non-trust land have their income deemed as "earned" and so may earn up to \$780 per year in net income from their land and not have it counted against SSI. Thus, the current treatment of agricultural income treats Indians more harshly than non-Indians.^{22/}

The SSI program also recognizes a number of general exemptions that disproportionately benefit non-Indians. For example, SSI recipients may own a home of any value or, if they are disabled, a vehicle of any value. This exemption benefits those persons who come into the SSI program with greater assets (e.g., house, car) and undoubtedly benefits non-Indians more than Indians whose poor housing and transportation problems relate to the general poverty of the Indian community. ^{23/}

In addition to the fact that the existing SSI program-wide exemptions generally help non-Indians more than Indians, four types of SSI policies concerning non-exempt money harm Indians SSI recipients with trust income far more than non-Indians with other types of countable income.

* 1) Use of estimates of income based on prior years' lease records to determine current SSI benefits disproportionately harms Indian SSI recipients. There is unanimous agreement among BIA officials whose letters appear in the briefing material that income from trust lands is not predictable. Statistical proof on a case-by-case basis of the unreliability of this money has resulted in some favorable administrative law decisions ruling that estimates are inappropriate and unauthorized,^{24/} but the practices of estimating income continues in the majority of cases.

The result of estimating income is that Indian elders are constantly either "underpaid" (when the estimated trust money does not arrive) or "overpaid" when the trust money arrives unexpectedly. It is important to keep in mind that the SSI recipients are people living in poverty, and that to be told that three months ago they received \$105 too much from SSI and that it must be repaid is both impractical and harsh. The SSI recipient who is struggling to make ends meet undoubtedly used the \$105 for food or fuel or some other base necessity when it was received.

There is no comparably unpredictable income outside of the Indian lease income context. Non-Indians cannot own land that generates "unearned income" and still remain eligible for SSI.^{25/} If SSI recipients have repeated problems with earned wages or variable interest payments, they have the ability to change their circumstances to prevent or mitigate the problem. Low-income Indian elderly do not have the ability to stop their lease payments without harm to the other heirs who are usually family members.

* 2) The second SSI policy which disproportionately harms low income Indian elderly and disabled recipients is SSI's practice of using underpayments of SSI benefits to unilaterally offset overpayments. Because of the use of unreliable estimates of trust income, tribal members on SSI are repeatedly underpaid when lease money does not arrive when estimated, and overpaid when it arrives in a higher amount than estimated.

Before 1990 the SSI program would often refund the SSI payment due once an erroneous estimate of lease income was corrected. This more equitable policy was changed in 1990 when the U.S. Supreme Court in Sullivan v. Everhart ^{26/} sided with the Social Security Administration's position that for reasons of administrative efficiency it should be allowed to simply apply any occurring overpayments to any anticipated underpayments. Surely no low income SSI population is more harmed by this practice than Indian elderly with irregular lease income. The SSI program now benefits from the use of unreliable estimates, as underpayments are a source of money from which overpayments can be more quickly collected. ^{27/}

An example of how the offsetting works:

If lease income of \$420 is estimated for December, but does not arrive until March, the claimant will lose his or her \$400 December SSI check, and have no income, and then in March incur an unavoidable overpayment of \$400 for March, which will be collected from the unpaid "netted" December benefits. For those with more lease income the potential harm and financial insecurity is even greater.

In some cases the yearly lease and grazing income trickles in over seven or eight months of the year. SSI's attempts to anticipate these funds causes year-round financial insecurity. If the total income is \$2,000 or \$3,000 the potential for harm is greater than if the income is less, for several full SSI checks may be stopped based on erroneous estimates of lease income. The result is that vulnerable elders are left with neither SSI or lease income during several months a year.

• 3) The third policy which disproportionately harms Indian elderly with trust income is that of counting previously assigned trust income as though it is available for present needs. The BIA, under the authority of federal regulations, allows future trust income to be assigned (typically to the tribal credit program) as security for loans. The assignment agreements have been considered by the SSI program to be no different than garnishments or collection of overpayments from ongoing benefits, although statutes which allow garnishments or collection typically limit the amount to be collected to prevent total impoverishment.^{28/} Assignments as security for a loan, on the other hand, often result in collection of all available trust income.

The authority for counting these unavailable, previously assigned amounts has long been questioned, and not until January 1991 did the SSI program promulgate a regulation that appears to authorize counting of unavailable income in situations beyond garnishment and collection of benefit overpayment from future benefits of that same program. The new regulations ^{29/} provides that: "We will also include as countable unearned income more than you actually receive if amounts are withheld from unearned income because of garnishment, or to pay a debt or other legal obligations, or to make any other payment such as payment of your Medicare premiums." We believe that under this new regulation it is likely that only Indian people will regularly lose full SSI checks and Medicaid, even though they have no assurance of any other monthly income or medical coverage.

• 4) The fourth policy which disproportionately harms Indian elderly is SSI's retrospective budgetary policy.

Income for SSI purposes will be counted in one of two ways to either create immediate ineligibility (or an immediate overpayment), or will be counted two months after receipt to reduce benefits. Larger lease payments (i.e., over \$428) create immediate overpayment or ineligibility. Small payments (less than the SSI amount) are counted two months later.

The problem with counting money two months later ("retrospective budgeting") is that the money received earlier is nearly always spent before the two month reduction of benefits occurs. A recent example involves one of our mutual clients who is 81 years old, a traditional,

widowed, blind tribal member. She received \$296.42 in lease income in June 1991 which resulted in the reduction of her August 1991 SSI check to \$96.68 (This includes a \$41.45 deduction to collect SSI overpayments. Our client was unable to save any of her June income and thus had only \$96.68 to pay her August food and shelter bills.

The "retrospective budgeting" policy harms Indian SSI recipients with individual trust income more than other recipients because the Indian trust income is irregular and unpredictable. Other types of income, for example Social Security retirement benefits, are paid in regular monthly payments, or, like wages or private trust agreements, can be adjusted to mitigate the conflict with SSI policies.

Medicaid: Loss of SSI Causes Loss of Medicaid Benefits. Persons receiving SSI are considered "categorically eligible" for Medicaid benefits. In some states suspension of SSI benefits, even for one month, will cause loss of Medicaid coverage for that period. This problem is particularly great in Arizona where elderly and disabled Indians losing SSI benefits must reapply for Medicaid coverage to the state's Arizona Health Care Cost Containment Systems (AHCCCS) program. The reapplication not only involves burdensome paperwork but requires a visit off-reservation to the nearest state AHCCCS office.

The loss of Medicaid in other states, we are told, too often means that an elder receives less medical care than if Medicaid coverage were retained. One reason for this is that the Indian Health Service coverage is much more limited than Medicaid coverage.^{30/} The practice of suspending Medicaid coverage when SSI benefits are suspended is not universal. The state of Washington believes that Medicaid must be suspended only if SSI is completely stopped, not when it is only suspended for a short duration.

The Medicaid coverage issue has become even more confusing with the Social Security Administration's promulgation of the unavailable income regulation quoted above. In the summary of the regulation, SSA states: "To the extent that Medicaid eligibility is based on the XVI (SSI) eligibility, these regulations also affect the Medicaid program."^{31/} Again, the adverse impact on elderly and disabled Indians is disproportionate. In all likelihood only Indians with trust land have a source of income that can be completely taken by a third party based on contractual relationships.

BIA General Assistance. While the major problems with trust income occur in the context of SSI and Medicaid, the Bureau of Indian Affairs' own harsh treatment of trust income for purposes of BIA General Assistance seems particularly indefensible, as it is not only a violation of its own trust responsibility but also raises serious conflict of interest issues with the agency. Thus we will briefly discuss the General Assistance policies.

Presently benefits are based on unreliable estimates of annual income. A letter from Northern Idaho Agency contained in the briefing book describes the case of a Nez Perce family of five denied BIA General Assistance based on an estimate of the prior year's trust income (\$2,692 from 14 parcels of land) although they had received no income in the present year. ^{32/}

The BIA is presently considering the SSI type of month-to-month counting of income rather than the present annualization. This would provide a considerable measure of relief to families who have been denied General Assistance because of larger amounts of trust income, but it would be harsher on persons with less trust income ^{33/}. It would also create even greater bureaucratic problems for the social services branches on reservations with significant allotted land. As with SSI, the trust income will likely put General Assistance recipients in a continual state of overpayment as the money cannot be accurately predicted.

The General Assistance programs do not now have any effective system for routine collection of overpayments. Each change in payment amount now requires about seven different entries into written and computer records, in addition to letters of notification to clients. To repeat this for each small lease payment will be totally impossible with current staffing levels.

WHY IS THE EXEMPTION LEVEL IN H.R. 2737 SET AT \$4,000?

We have been asked why the exemption level is set at \$4,000 in the pending legislation. Our answers are several:

- 1) It Does Not, in Reality, Exceed the Per Capita Exemption The Per Capita exemption and exemptions such as the Alaska Native Claims Settlement Act Amendments (ANCSA) are not really lower. The Per Capita exemption ^{34/} is \$2,000 per payment (although few tribes will ever make per capita payments that high). The ANCSA exemption ^{35/} is \$2,000 per each family member per year. H.R. 2737 would protect income received predominantly by the oldest tribal members or head of household, and would not often apply to other family members, thus the financial benefit per family very often be less than in the per capita situation.
- 2) Protects Persons Most in Need. Although the average yearly trust income is estimated at \$420 per year, a very small number receiving trust income receive yearly income in the \$2,000-\$4,000 range. In most cases they are the oldest, most traditional tribal members whose income should be especially protected. Very often this same population also has special diet, transportation or health-related expenses.
- 3) Reduction of Paperwork by Federal Agencies. One of the significant reasons for the \$4,000 exemption level is to reduce the paperwork burden on administrative agencies such as the BIA and Social Security Administration. This can best be accomplished if the great majority of lease income cases are well within the exemption ceiling. In these cases a "developmental tolerance" policy can be adopted whereby amounts reported under a certain "safe" level, for example \$2,500, do not have to be verified. SSI currently uses this "developmental tolerance" policy in the administration of a number of exemptions.
- 4) Consistency with Standards of Management of Trust Funds. The \$4,000 amount allows the BIA to manage trust money in keeping with the fiduciary standards of a trust relationship.

* 5) Political Reality. The \$4,000 cap on individual Indian trust income provides assurance to any concerned party that this exemption will not benefit those who have no real need for federal benefits. With \$4,000 in trust income and full SSI benefits a tribal elder would still be within the HUD program "very low income" category. While the legal basis for a full exemption of Indian trust income is sound, we are convinced that it would not be politically viable to see a full exemption, and thus we strongly support this compromise.

NOTES

1/ E.g., The Indian Reorganization Act provides that all individual Indian lands acquired under that Act shall be held in trust by the United States for the individual allottee. 25 U.S.C. §46.

2/ See generally, F. Cohen, Handbook of Federal Indian Law (1982 ed.), pp. 62-105.

3/ *Id.*, p. 138.

4/ *Id.*, p. 102, fn. 330, 12 Stat. 951.

5/ *Id.*, p. 138.

6/ BIA FY1992 Budget Justification, p. 2 (10,226,180 acres).

7/ A "fee patent" is the term used for the document of ownership proving the land was not restricted or managed by the United States and could be freely sold. A discussion of the removal of restrictions on alienation is contained in Cohen, *supra*, at 619-623.

8/ 463 U.S. 206.

9/ *Id.* at 225. The Court describes the corpus of the Trust in that case, involving the sale of timber, as being "Indian timber, lands, and funds."

10/ E.g., leasing provisions of 20 C.F.R. Part 162; grazing provision of 20 C.F.R. Parts 166-168.

11/ 351 U.S. 1

12/ *Id.* at 6, 8-10.

13/ 645 F.2d 701 (9th Cir. 1981).

14/ The disproportionate administrative cost of managing fractionated lands was discussed at some length by the United States Supreme Court in 1986 in Hodel v. Irving, 481 U.S. 704, 406-10, 12-13.

15/ See attached briefing materials, Letter of Superintendent Cora Jones.

16/ 25 U.S.C. § 2201-11, later amended.

17/ A provision for escheat to the tribes of small fractional shares of individual trust land upon the death of the landowner (25 U.S.C. § 2206) was struck down by the U.S. Supreme Court in Hodel v. Irving, *supra*, as an unconstitutional taking from the heirs. Amended language has been challenged.

18/ 20 C.F.R. § 115.5.

19/ Capoeman, 351, U.S. 9 ("[T]he allotment system was to protect the Indian interest [therefore] the income derived directly therefrom."); Mitchell, 463 U.S. 225 ("[W]here the Federal Government takes on or has control ... over monies or properties ... the fiduciary relationship normally exists.")

20/ Mitchell, *supra*, involved both tribally and individually owned allotted lands.

21/ It is a political relationship. See Levanthol, American Indians - the Trust Responsibility: An Overview, 8 Hamline Law Review, 625-40; F. Cohen, Handbook of Federal Indian Law (1982 ed.), 207-27.

22/ See also, other plans for self-support, 20 C.F.R. §§ 416.1124(c) (13), 416.1180, 416.1181, 416.1182, where income is disregarded.

23/ Similarly, liberal SSI and Medicaid "transfer of assets" rules which allow spouses to keep more family assets and income when the other spouse is in a nursing home obviously benefit more those who are better off than very low income people who have no assets to shelter.

24/ Decisions of Chief Administrative Law Judge Raymond B. Little, Seattle Regional Office, Social Security Administration Office of Hearings and Appeals, in a series of 1990-91 Evergreen Legal Services Administrative Hearings.

25/ The exemption for Indian land has consistently been recognized by the SSI program and other federal programs. It is now codified at 25 U.S.C. §1408 which S. 754 will amend. This exempt land is a source of income that non-Indians will never have.

26/ 110 S.Ct. 960.

27/ SSI law restricts collection of overpayments to 10% of current income. The result of Sullivan v. Everhart is, however, to allow collection from 100% of SSI benefits previously unpaid.

28/ Courts, in upholding SSI's unavailable income regulations, have stated that they would not approve a regulation which allowed total impoverishment of an SSI recipient. Lyon v. Bowen, 802 F.2d 794, 800 (5th Cir. 1986); Robinson v. Bowen, 828, F.2d 71, 73 (2nd Cir. 1987); Szlosek v. Secretary, 674 F. Supp. 944, 951 (D. Mass. 1987), *aff'd*, 861 F.2d 13 (1st Cir. 1988); Haelea v. Bowen, 871 F.2d 48 (7th Cir. 1989).

29/ 20 C.F.R. §416.1123(b), published Volume 56, No. 19 (p. 3212) of the January, 29, 1991, Federal Register.

30/ Indian Health Service care is often limited to acute and emergency care.

31/ *Supra*, Note 26, 3212.

32/ Memorandum of Joe Paradise, Director of Social Services, Northern Idaho Agency to Superintendent of the Umatilla, Northern Idaho and Yakima Agencies, dated April 21, 1989.

33/ Prorating \$300 in trust income is generally considered less harsh than taking \$300 out of one month's benefits (which may be only \$320).

34/ 25 U.S.C. §117(b), incorporating 25 U.S.C. §1407 exemption language.

35/ P.L. 92-203, and its Amendments of 1987 (P.L. 100-241).

Attachment
B

WHAT IS NOT "INCOME" FOR SSI PURPOSES

It is often just as important to know what SSA does not count as income as what it does count. This is helpful in assessing eligibility and the amount of SSI that a person should receive. It is also important in assisting family members and others to identify ways in which they can assist the SSI recipient without affecting the recipient's eligibility for SSI or the amount of the person's benefit. While SSA has many rules about the kinds of contributions which it will not count as income, recipients and their families and friends are generally not familiar with the rules. In addition, because there is some uncertainty in some areas, such as trusts (see the discussion in the resource section), advocates are often themselves not sure about the scope of items which are not counted as income. This section lists the items which SSA has stated are not counted as income.

20 C.F.R. (416.1103 lists many items which are not treated as "income" for SSI purposes. Unless there is a specific statutory exception for income which is not to be counted, SSA applies one basic principle in deciding whether something is income. If the contribution can not be used as food, clothing, or shelter or if the person cannot use the item to obtain food, clothing, or shelter, then it is not income. Id.

Shelter items which are not counted as "shelter": One area where SSI recipients tend to need assistance is in securing decent shelter. While most contributions for shelter are counted as income, it is important to focus on SSA's definition of "shelter." 20 C.F.R. (416.1130(b) defines "shelter" as:

"Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection."

This means that other contributions which might commonly be thought of as shelter are not considered to be "shelter" for SSI purposes. Some examples of areas where assistance can be provided include home repairs, replacement of a water heater, insulation,¹ and telephone bills.

1. 20 C.F.R. (416.1103(i) specifically exempts weatherization assistance from income. This includes insulation, storm doors and windows.

In each of these examples, it is important that the person who is paying the bill not give the recipient cash but instead pays the bill for the SSI recipient. This concept is included in 20 C.F.R. (416.1103(g), "Bills paid for you," although it is not spelled out clearly. There, SSA states that the payment of bills by someone else directly to the supplier is not income. SSA then qualifies this statement by saying that they count the value of anything the SSI recipient receives because the payment was made if it is "in-kind income." That term is defined in 20 C.F.R. (416.1102:

"In-kind income is not cash, but is actually food, clothing, or shelter, or something you can use to get one of these."

Because these items are not "shelter" (or food or clothing), they are not counted as "in-kind" income. SSA provides one example which is relevant:

"...[I]f your brother pays a lawn service to mow your grass, the payment is not income to you because the mowing cannot be used to meet your needs for food, clothing, or shelter. Therefore, it is not in-kind income as defined in (416.1102."

Despite the minimal nature of the contribution described in the example, it is important that advocates recognize the potential of this exception to the income rule.

Items which would not be counted as a resource and which are not food, shelter and clothing: SSA will not count as income any non-cash item which the SSI recipient receives if it would be excluded from resources in the next month. However, SSA does not apply this rule to items of food, shelter, and clothing. 20 C.F.R. (416.1103(j)).

SSA provides a list of resources which it will not count in 20 C.F.R. (416.1210 through 416.1237. For example, household goods and personal effects are excluded as a resource to the extent that their equity value does not exceed \$2,000.² 20 C.F.R. (416.1216(b)). Therefore, if a person wished to provide an SSI recipient with a household appliance, such as an air conditioner or an electric fan, so long as the overall value of the SSI recipient's household goods and personal effects did not exceed \$2,000, the item also would not be counted as income to the SSI recipient.

2. To the extent that the equity value exceeds \$2,000, the excess is counted against the general resource limitation, also currently set at \$2,000 for an individual. 20 C.F.R. (416.1216(b)).

It is important to note that SSA does not apply this rule to food, shelter and clothing. The most significant of these is shelter. While the value of a person's home is excluded as a resource, SSA will treat the contribution of a home as income in the first month in which it is received. In "example 2" in 20 C.F.R. (416.1103(j)), SSA states:

"You inherit a house which is your principal place of residence. The value of this inheritance is income because the house provides you with shelter and shelter is income. However, we value the house under the rule in (416.1140."

However, as noted in the example, if the person is residing in the home, SSA will apply the presumed maximum value (PMV) rule and will only reduce the person's benefit by the amount of the 1/3 reduction plus \$20.00. See discussion of the PMV.

The same rule applies if a family wishes to pay the SSI recipient's rent for him/her. If the amount that is involved is less than or equal to 1/3 of the SSI federal benefit rate plus \$20.00, the full amount will be counted as income. If the person's rent is more than that figure, for example \$400, SSA will not count all of the contribution as income, only the portion equal to 1/3 of the federal benefit level plus \$20.00.

Assuring that a transportation ticket will not be counted as "income": One fairly common problem which SSI recipients have faced is having the receipt of a bus, train, or plane ticket counted as income. Typically, a family member sends the SSI recipient a bus or train ticket so that s/he can join the family for a visit, often around the holidays. Later, when SSA learns that the SSI recipient received the ticket, they determine that the ticket could have been cashed in and used for food, shelter, or clothing and, therefore, is income to the SSI recipient. SSA then decides that the person has been overpaid and issues a notice of overpayment for the amount of the ticket.

A recent change in the law should eliminate this problem in most cases. Section 8011 of Public Law 101-239 amended 42 U.S.C. (1382a(b) to add a new item to the list of exclusions from income. Section 1382a(b)(15) provides that the "value of a commercial transportation ticket" will not be counted as income if:

1. it is provided for travel by the SSI recipient or his/her spouse "among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands,"
2. it is "received as a gift," and
3. it is not converted to cash.

In an unfortunate reading of the provision, SSA has indicated in a POMS transmittal that, "The law did not provide an exclusion from resources for tickets which are retained into the following month, therefore, resource policy with regard to such tickets is unchanged."³ The POMS section itself states that "The value of a ticket for domestic travel which is retained into the month following its receipt is evaluated under the resource rules as of the first moment of the month following the month of receipt..." SI A00840.005(C)(3). This simply adds confusion to an area which the Congress was trying to simplify. It is possible that SSA's position on this will change. In the meantime, the following practical pointers should be noted:

1. Counting the ticket as a resource in the month after it is received (if it has not yet been used) will not affect the eligibility of anyone whose other countable

3. SSA Transmittal No. 28 (March, 1990) accompanying POMS SI A00840.005.

resources when added to the value of the ticket total less than \$2,000.

2. If the advocate is in the position to counsel someone before s/he receives the ticket, inform them that, if the third party purchases the ticket in one month for use in the next month, the third party should hold on to the ticket until the beginning of the month in which it will be used.

This new provision took effect on March 1, 1990.⁴ It is SSA's position that the provision only applies to tickets received on or after that date.⁵ However, there is a strong legal argument that the change applies to all cases which were pending at any level on March 1, 1990, as well as all cases in which a ticket was received prior to the date but

not act to identify an overpayment until on or after
, 1990.6

ion 8011(b) of P.L. 101-239 provides that "The
nts made by subsection (a) shall take effect on the
of the 3rd calendar month beginning after the date
enactment of this Act."

SI A00840.005f(C)(2): "This policy is effective for
received on or after March 1, 1990."

issue arises with regard to most of the effective
visions which have been included in SSI amendments
Congress in the 1987 and 1989 Acts. A district court
nois has recently held that one of the provisions in
7 legislation applies to all cases pending on the
ve date, not just to those which arose on or after
te. In Gay v. Sullivan, Civil Action No. 87 C 441
1. May 10, 1990), the court held:

his decision requires OBRA (9106 to apply to all
aims pending on the date the law became effective,
ril 1, 1988. The amendment applies retrospectively to
l claims pending on April 1, 1988 (and not just
spectively to claims filed after that date.) The
venth Circuit has held that statutes, such as OBRA
87, which are remedial in nature (footnote omitted),
all be applied to all claims pending at the time of
e statute's enactment. See Johnson v. Heckler, 769
2d 1202, 1214 (7th Cir. 1985). In addition the United
ates Supreme Court has held that courts must apply an
endment to pending cases 'unless doing so would
sult in manifest injustice or there is statutory
rection or legislative history to the contrary.'
Adley vs. Richmond School Board, 416 U.S. 696, 711
974). See also, United States v. Schooner Peggy, 5
S. (1 Cranch) 103, 110 (1801); Brown v. M&M Mars, 883
2d 505, 513 (7th Cir. 1989); Thorpe v. Housing

What can be done about cases which are not covered by the new law?

There will be potentially two categories of tickets not protected by the change in the law: (1) tickets for non-domestic travel (the most common might be to Mexico, Canada, and Israel) and (2) if SSA prevails in its view of the application of the effective date, all cases in which the person received a ticket prior to March 1, 1990. There are three points which advocates should note with regard to these tickets.

While this will not work for the poorest families where there is no credit card, advocates should note that, even under its old rules (which still exist), SSA did not count the ticket as income if the relative charged the ticket to his/her own credit card. When this occurs, SSA takes the position that the ticket is not countable income to the recipient because, if the recipient attempted to cash it in, s/he could not receive the cash. Instead, a credit would be made to the relative's account. As a result, the SSI recipient would not have access to the cash and it could not be used for food, clothing or shelter. This policy is spelled out in Social Security Ruling 80-22.7

Second, where the ticket is a non-refundable ticket, such as those known as "super-savers," SSA should not count the ticket as income because it has no cash value.

Third, in Buchbinder v. Bowen, 709 F.Supp. 389 (S.D.N.Y. 1989), the plaintiff SSI recipient had been given a sum of money, in cash, to locate the heirs of his nephew. He used the money to travel to Argentina and Poland as part of his effort to identify the heirs. SSA had determined that the funds were income in the month received and resources in every month after that in which he held them before taking the trips. The district court reversed, finding that the oral agreement he had with the person who gave him the money constituted a trust under New York state law and that the funds were never available to him for his own support and maintenance.

Authority of the City of Durham, 393 U.S. 268 (1969); Matter of Busick, 831 F.2d 745 (7th Cir. 1987)."

The court then concluded retroactive application of the provision would not result in "manifest injustice" to the Secretary.

7. The ruling is included at the end of the materials. See Appendix 4.

In-kind assistance provided by a non-profit organization which is based upon need: 42 U.S.C. (1382a(b)(13) provides that the Secretary must exclude from income "any support or maintenance assistance" provided to an individual by a non-profit organization, if it is "based on need for such support or maintenance." ⁸ This provision technically temporarily expired on September 30, 1987. ⁹ Congress made the provision permanent in the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, and also provided that the new provision was effective back to the date of expiration of the earlier provision. ¹⁰

Despite the fact that this provision is now permanent, advocates periodically discover that some SSA staff are not aware of the rule or are operating under the misconception that the rule expired and was not extended. As a result, there have been a few cases in which SSA staff have reduced a recipient's benefits by the "value" of the meals which s/he receives at a soup kitchen or the value of the firewood which s/he is given by a non-profit so that s/he may heat the home. When the error is pointed out, SSA staff have been quick to make the correction.

Advocates should point out the significance of this exception to non-profit organizations in their area. These

8. The fact that the assistance is provided based upon need must be certified by a State agency or by SSA. SSA retains lists locally of non-profit agencies which provide assistance based upon need. A non-profit interested in assisting those in need should contact SSA to be added to the list. See also 20 C.F.R. (416.1157(b) and (c).

9. Aware that the provision expired on September 30, 1987, SSA issued instructions to its staff before that date telling them to begin counting in-kind assistance from non-profits on October 1, 1987. See Emergency SSI Instructions OSSI-87, SJB-6-1 (September 18, 1987). On October 16, 1987, the New York Times reported SSA's plans, see "New Reagan Policy to Cut Benefits for the Aged, Blind and Disabled" (page 1). Later that same day, the Secretary of HHS waived the expiration date by creating a demonstration project. See "U.S., Facing Criticism, Drops Plan to Cut Benefits for Poor," New York Times, page 1 (October 17, 1987). Under the "demonstration project," the Secretary created a six-month extension of the exclusion. See 52 Federal Register 38969 (October 20, 1987). In order to benefit, an SSI recipient or applicant had to "consent" to inclusion in the project. Id. at 38970.

10. Section 9101 of Public Law 100-203.

organizations are uniquely situated to assist an SSI recipient with groceries, meals, clothing, and even a rental subsidy (if paid directly to the landlord, not in cash to the recipient) without any of the contributions having any effect on the person's eligibility for SSI benefits.

Medical care and services: Most medical care and services are not counted as income. They will not be income if they fall into one of the following categories:

1. If the service is provided for free.
2. If the payment for the service is paid directly to the provider by someone other than the recipient.
3. If the service is room and board which the person receives during a medical confinement.
4. If the person receives assistance from a federal, state, or local government program whose purpose is to provide medical care or services, then the assistance will not be counted as income. This includes food, clothing, or shelter if it is provided under such a program. It also includes vocational rehabilitation services.
5. In-kind assistance provided by a non-governmental program whose purpose is to provide medical care or services. This does not include food, clothing or shelter.
6. Cash if it is provided by a nongovernmental medical care or medical services program or under a health insurance policy if the cash is either:
 - a. repayment for program-approved services for which the person has already paid,
 - b. a payment restricted to the future purchase of a program-approved service.

The cash can not be for food, clothing or shelter.

7. If someone else pays the recipient's insurance premium directly to the insurance company, that is not counted as income.

20 C.F.R. (416.1103(a))

Special accounts established by a community to help meet the costs of one person's health care: Over the years, there have been times when a community will act collectively

to raise the funds needed by a local resident for some very expensive form of medical treatment. In the past, the question has arisen as to whether the funds are income to the individual and whether the account in which the funds are collected is a countable resource for the individual. The Social Security Administration has indicated that, if it is contacted prior to the creation of the account, it will advise the community representatives as the steps to take to avoid affecting the person's SSI.

As a practical matter, these cases sometimes arise after the account has been established, when SSA is saying that the funds are available to the person and must be counted. Under those circumstances, it will be important to establish that the funds were provided for a specific purpose and are expected to be spent for that purpose. If the problem is not easily resolved, the advocate should consider advising the client to contact his/her local Congressional representative to intervene with SSA.

Social services: SSA does not count social services as income if they fall into one of the following categories:

1. Cash or in-kind assistance under any federal, state, or local government program whose purpose is to provide social services.
 - a. This includes vocational rehabilitation.
 - b. This does not apply where the assistance is received in return for a service which the person receives.
 - c. An example of a cash contribution is money provided by the Veterans Administration to purchase aid and attendance.
2. In-kind assistance provided by a nongovernmental program whose purpose is to provide social services. However, this can not be food, clothing, or shelter.
3. Cash provided by a nongovernmental social services program if it meets one of two requirements:
 1. It is repayment for program-approved services for which the person has already paid.
 2. The payment is restricted to the future purchase of a program-approved service.

The cash can not be for food, clothing or shelter.

Additional items which are not income

There are many other items which also are not counted as income. These include:

The first \$20.00 of unearned income received in a month¹¹ 20 C.F.R. (416.1124(c)(12))

Up to \$20.00 in unearned income in a month if it received on an irregular or infrequent basis¹² 20 C.F.R. (416.1124(c)(6))

Income tax refunds 20 C.F.R. (416.1103(d)). However, note that refunds of federal taxes and advance payment by employers of the earned income tax credit is not treated as totally excluded. Instead, it is subject to the earned income disregards. 20 C.F.R. (416.1110(c) and (416.1111(c)). [See discussion under work incentives.]

*EITC is
now
excluded
OBRA '90*

Payments by credit life or credit disability insurance
20 C.F.R. (416.1103(e))

Proceeds of a loan 20 C.F.R. (416.1103(f)) [See discussion under in-kind income.]

Receipts from the sale, exchange, or replacement of a resource 20 C.F.R. (416.1103(c))

Replacement of income the person has already received
20 C.F.R. (416.1103(h))

Some earned income is not counted 20 C.F.R. (416.1112) [See discussion under work incentives.]

A public agency's refund of taxes on real property or food 20 C.F.R. (416.1124(c)(1))

Assistance based on need which is wholly funded by a state or a political subdivision of a state 20 C.F.R. (416.1124(c)(2))

11. This rule is not always applicable where the other source of unearned income is also a needs-based program. See 20 C.F.R. (416.1124(c)(12)).

12. SSA defines "infrequent or irregular" as "if you receive a type of income listed in (416.1121 only once during a calendar quarter from a single source or if you cannot reasonably expect it." 20 C.F.R. (416.1124(c)(6)) SSA also will not apply this rule if the amount that is received in any month exceeds \$20.00. Id.

Grants or scholarships, but only the portion which is used for paying tuition, fees, or other necessary educational expenses¹³ 20 C.F.R. (416.1124(c)(3))

Food which the person (or spouse) grow, if s/he also consumes it 20 C.F.R. (416.1124(c)(4))

Interest earned on burial accounts¹⁴ 20 C.F.R. (416.1124(c)(9))

Disaster relief assistance¹⁵ 20 C.F.R. (416.1150)

Income which is set aside in an approved plan for achieving self-support (PASS) 20 C.F.R. ((416.1124 (c)(13), 416.1180, 416.1181, and 416.1182 [See discussion under work incentives.]

Income which other federal laws bar from being counted in SSI Immediately following 20 C.F.R. (416.1182, there is a lengthy list of federal laws which bar SSA from counting specific benefits as income in the SSI program. See also 20 C.F.R. (416.1124(b)). One important exclusion is relocation assistance provided by the federal government.¹⁶ It should

13. SSA will count "any portion set aside or actually used for food, clothing, or shelter."
14. The interest must have been earned on or after 11/1/82 or since the person became an SSI recipient, whichever came later. 20 C.F.R. (416.1124(c)(9)). Advocates should note that there is a dispute regarding the treatment of interest that has accumulated on the burial account of a person who was an SSI recipient, loses that status, and then later seeks to return to SSI status. SSA takes the position that, to the extent that the accumulated interest results in the burial account exceeding the \$1500 limit, it disqualifies the person from eligibility for SSI even though it accumulated during the period when s/he was previously receiving SSI.
15. This includes assistance under the Disaster Relief Act of 1974 and any Federal assistance provided because of a catastrophe which the President declares to be a major disaster. 20 C.F.R. (416.1124(c)(5)). SSA spells out the rules on disaster relief in 20 C.F.R. (416.1150). Of particular note, if as a result of a disaster, an SSI recipient is forced to leave his/her home and move in with others and receives support and maintenance in that other household, SSA will not apply the 1/3 reduction for up to 18 months. Id.
16. See "II(d) Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91-646,

be noted that this rule does not apply to identical assistance provided by a state.¹⁷

Certain death benefits are excluded. 42 U.S.C. ((1382a(a)(2)(D) provides that where a person receives a payment "occasioned by the death of another person," the payment will be counted as income "to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial." In the past, this rule applied only to life insurance benefits (and was subject to a cap which has been eliminated.) It did not apply to gifts and inheritances. Effective April 1, 1988, the rule now also applies to gifts and inheritances. The Secretary defines the excluded expenses to include "related hospital and medical expenses, funeral, burial plot, and interment expenses, and other related costs." 20 C.F.R. (416.1121(e).

Payments made to Holocaust survivors: As a result of a Ninth Circuit Court of Appeals decision in 1984, SSA does not count as income payments which are received as reparations from foreign countries to Holocaust survivors.

Payments to Japanese internees by the United States: Payments made to individuals of Japanese ancestry who were interred in camps in the United States during World War II are not to be counted as income or resources in federal public benefits programs.¹⁹

Agent Orange court settlement payments: Last year, Congress passed two separate laws which bar SSA from counting Agent Orange settlement payments as income or resources for SSI purposes.²⁰

the United States Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636)."

17. See Murray v. Bowen, 786 F.2d 940 (9th Cir. 1986).

18. See Grunfeder v. Heckler, 748 F.2d 503 (9th Cir. 1984).

19. Section 105(f)(2) of Public Law 100-383 provides that the payments shall not be counted "as income or resources for purposes of determining eligibility to receive benefits described in section 3803(c)(2)(C) of title 31, United States Code, or the amount of such benefits." 31 U.S.C. (3803(c)(2)(C)(i) is SSI. Other programs where this rule applies include AFDC, Medicaid, Food Stamps, section 336 of the Older Americans Act, Low-Income Home Energy Assistance, housing assistance, Title XX social services. Id. (i) through (xvi).

20. Section 10405(a) of Public Law 101-239 excludes "the payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)" from being considered as income or resources in a long list of federally funded or federally assisted programs. Section 10405(a)(2)(A) lists SSI. This provision was effective, retroactive to January 1, 1989. Section 10405(b). See also Section 1 of Public Law 101-201 which creates a blanket exclusion from consideration in all federal programs rather than providing a list of the programs affected. This provision also took effect on January 1, 1989.

EXHIBIT B

THE REAUTHORIZATION OF THE OLDER AMERICAN ACT
The Native American Programs Act and the Impact of the
Older American Act on Older Indians and Hispanics

Hearing Testimony of

ELIZABETH J. WHITE

Washington State Indian Council
on Aging, Chair:
Advocates for Tribal Elderly,
Acting Project Director

Before The

UNITED STATES SENATE

LABOR AND HUMAN RESOURCES COMMITTEE
SUBCOMMITTEE ON AGING
THE HONORABLE BROCK ADAMS, CHAIR

AND THE
UNITED STATES HOUSE OF REPRESENTATIVES
EDUCATION AND LABOR COMMITTEE
SUBCOMMITTEE ON HUMAN RESOURCES
THE HONORABLE MATTHEW G. MARTINEZ, CHAIR

May 4, 1991

Yakima Nation Cultural Center
Toppenish, Washington

The following topics have been identified by the Advocates for Tribal Elderly board of directors as priority issues for the group. This listing will, of course, be expanded as the results of our elders' survey are known:

SOCIAL SECURITY TITLE II SURVIVORS AND DEPENDENTS BENEFITS

Birth Certificates

Title II benefits are frequently delayed or denied to elderly Indian applicants who are told (or who believe they have been told) that they must have a birth certificate to prove their age before any benefits can be awarded. Many elderly Indian people were born at home, and have little or no formal education, and belong to traditional religions which do not have baptism or first communion records. SSA must be more flexible in the types of proof of age it requires and be more willing to accept that an exact date of birth may not be known. Bureau of Indian Affairs, documentation of birthdates, valid to prove birth dates for all BIA purposes, should be accepted as conclusive proof of age in the absence of a birth certificate.

Indian Custom Marriages

Widows continue to lose survivors benefits because SSA does not always recognize their traditional marriages, or because SSA uses outdated tribal codes to assert, incorrectly, that the tribe itself no longer recognizes marriages according to traditional religious practices.

SUPPLEMENTAL SECURITY INCOME, TITLE XVI, BENEFITS

Income from Exempt Trust Lands

A few thousand low-income Indian elders, including hundreds in the Northwest, are kept in a perpetual state of financial insecurity and indebtedness to the federal government by SSI's insistence on counting small, irregular, tax exempt lease and grazing payments from their individual Indian trust lands. The Senate Select Committee on Indian Affairs and many Bureau of Indian Affairs officials insist that the trust responsibility, the high

fiduciary duty owed to Indian people to protect their resources and its income, means that these monies must be considered exempt. All other types of "Indian monies" are already exempt under various statutes.

The administrative cost to the BIA and SSI program of tracking and verifying these small payments exceeds the cost to SSI of the additional payments that would result from an exemption. Yet when legislation to exempt a reasonable amount of trust income was introduced last session it was halted, in major part because the Social Security Administration advised the Congressional Budget Office that it could see no administrative savings in an exemption.

The bipartisan exemption bill has now been reintroduced as S. 754. Advocates for Tribal Elderly will be discussing the cost savings aspect of the bill with SSI program in the very near future. The support of the Administration on Aging and your committees for this important legislation is greatly needed.

Exempt Resources

Elderly tribal members may have no exempt home or vehicle but in a few hundred cases a year elders sell an exempt trust asset, typically land or timber. There must be a reasonable, several-month exemption period allowed for the elderly to "spend down" this income. The land and timber are, according to federal statute, intended by federal Indians to be preserved for the "sole use and benefit" of the Indian owners. Often the sale proceeds are the only financial benefit that the elder will ever receive from the land or timber. The present system leads to incorrectly assessed overpayments and extended periods without any income while elders try often in vain, to document in detail to SSI how the land sale or timber sale monies were spent. Federal Indian policy is completely undermined in these cases.

Heirlooms and Regalia

A recurring, though not frequent, barrier to SSI eligibility is counting by SSI as a resource items that are tied to tribal religion and custom. These items include buckskin clothing, traditional beadwork, basketry, weaving or carving that is intended to be passed down to succeeding generations to preserve the culture of the tribe and the family. Knowledge that ownership of this traditional heirlooms might be considered an "excess resource" has a chilling effect on older tribal members who forego needed benefits out of the belief that they will be asked to sell their regalia or beadwork if they apply for SSI.

Treaty Fishing Equipment

In the Northwest, and perhaps elsewhere, many elderly traditional tribal members still fish or supervise family fishing activities pursuant to protected Treaty fishing rights. Although the fishing may only provide income for one or two months the elders are denied SSI for the rest of the year because their Treaty fishing equipment is considered to be an "excess resource." These types of conflicting federal policies should be resolved in favor of the protected Indian interest. Fishing gear used in exercise of Treaty rights should not be an excess resource for SSI.

Lack of Outreach

SSI notices sent to tribal elders are most often never understood or never fully understood because of the elders' limited English proficiency. The problem is compounded because the Indian languages are generally not written languages and thus no alternate written notice is possible. If SSI wishes its notices to be understood it should provide outreach workers to explain the notices and answer questions in the Indian community.

INDIAN HEALTH SERVICES**Alternative Resources**

Elderly and traditional tribal members are particularly offended when they are told they must go to the state welfare

office and apply for Medicaid before they will be considered for IHS Contract Care coverage. Elders too often avoid needed health care because of this bureaucratic stumbling block. An agreement should be reached between IHS and Medicaid for a set, proportional payment of these medical costs without subjecting old and ill Indian people to the red tape of two huge bureaucracies, with their long applications and complex eligibility requirements. Other Contract Care requirements, such as preapproval for many medical procedures are disproportionately burdensome on tribal elders who firmly believe in their unqualified right to medical care and should be changed.

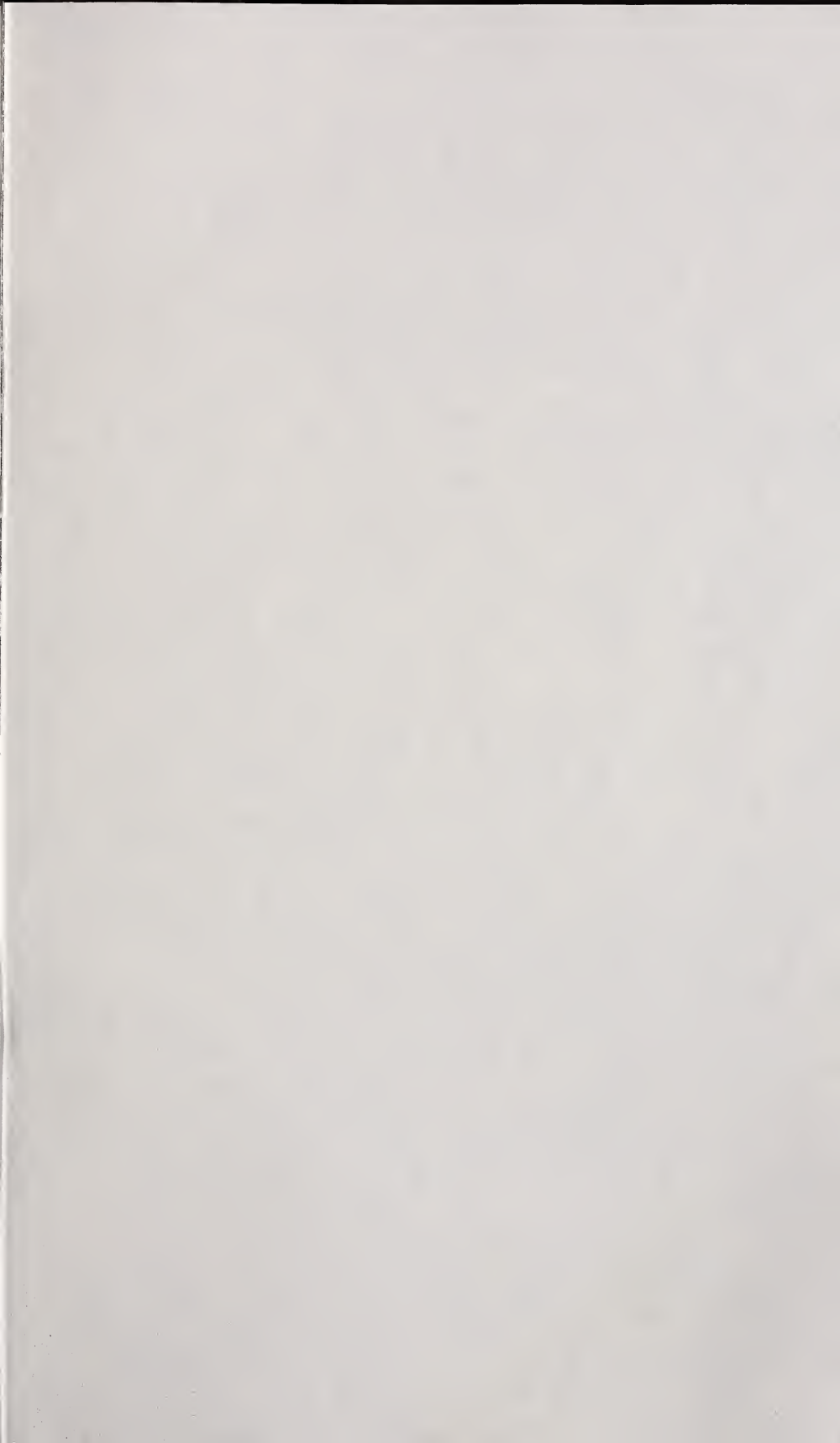
Lack of Geriatric and In-Home Health Care

The Indian Health Service has no program of geriatric health care for older Indian patients and a very inadequate in-home health care system. This absence of attention to the health needs of Indian elders is particularly unfortunate and inappropriate as Indian elders are on many reservations adamantly opposed to any residential or nursing care placement, and thus they are greatly in need of geriatric and in-home health services on their own reservations, and in their own homes.

The long-term care issue has been of particular concern to the WSICOA board for many years. The boards of directors of Advocates for Tribal Elder and WSICOA look forward to working with Dr. Jackson on an interdepartmental and interagency solution to the long-term care problems of tribal elderly.

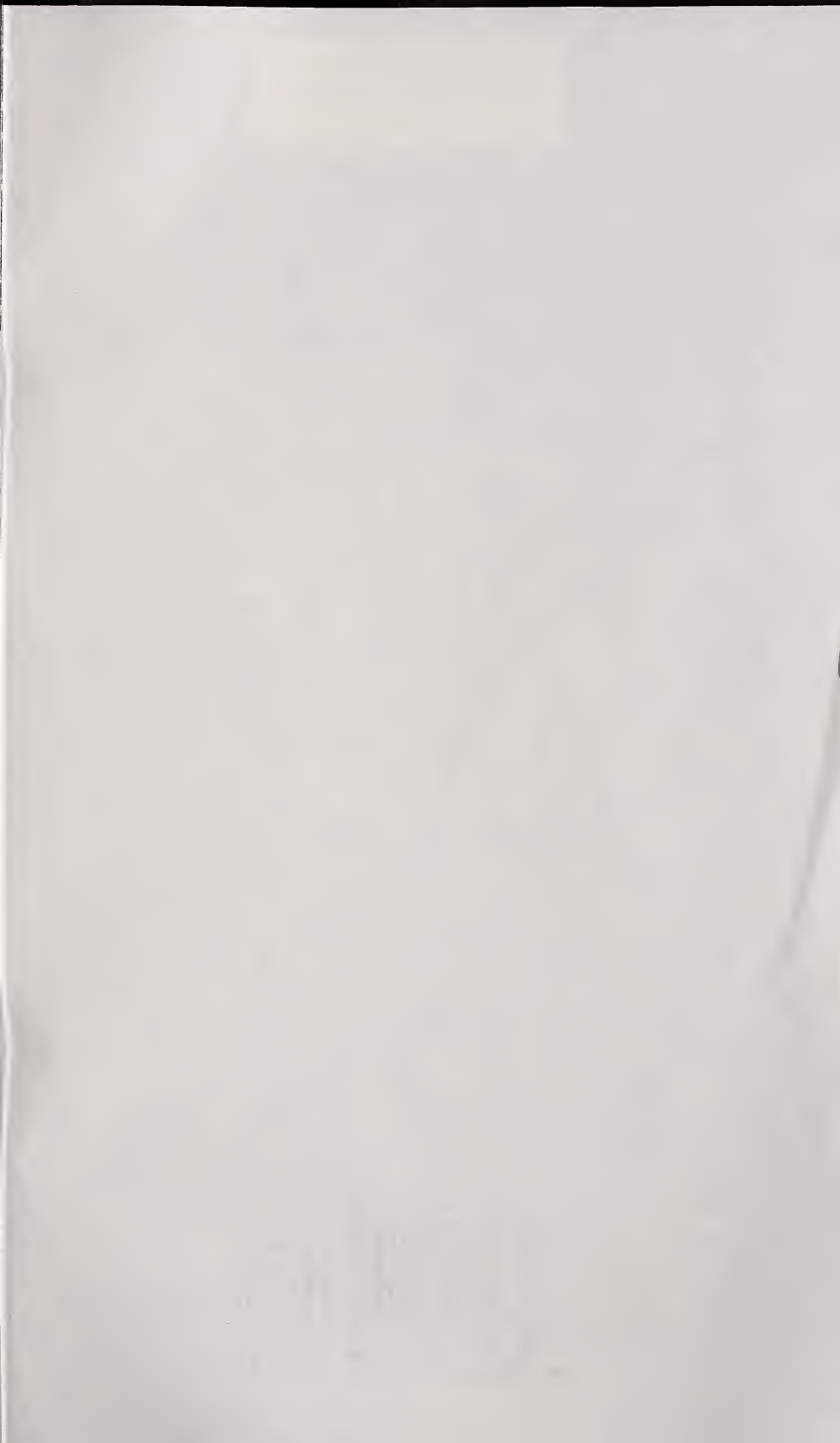
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